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ABSTRACT

The purpose of this publication is to provide discussion of some of the most difficult and controversial issues surrounding body image and eating disorders, specifically, anorexia nervosa and bulimia nervosa. It includes contributions from a number of nationally and internationally recognized clinicians and researchers in the field. It also incorporates valuable contributions from community workers and consumers associated with body image and disordered eating issues. Part 1, "Challenging the Body Culture," includes a chapter that presents recommendations for action, along with a chapter that introduces the issues associated with body image and disordered eating behaviors. Part 2, "Social Factors and the Body Culture," deals with issues related to socio-cultural concerns: media, cosmetic surgery, and other emerging issues related to body culture and eating disorders. Part 3, "Treatment Issues--A Multidisciplinary Perspective," discusses the treatment of eating disorders from a number of clinical perspectives, such as psychiatry, nutrition, psychology, and nursing. Part 4, "Community Voices," presents material relating to "at-risk industries," community organizations, and personal stories and poems of "lived experience" as a sufferer, partner, parent, or sibling. The Epilogue encapsulates the tragedy and frustrations of the many families, careers, and professionals who have been touched by this public health issue. (Contains 12 tables over 590 references.) (ADT)

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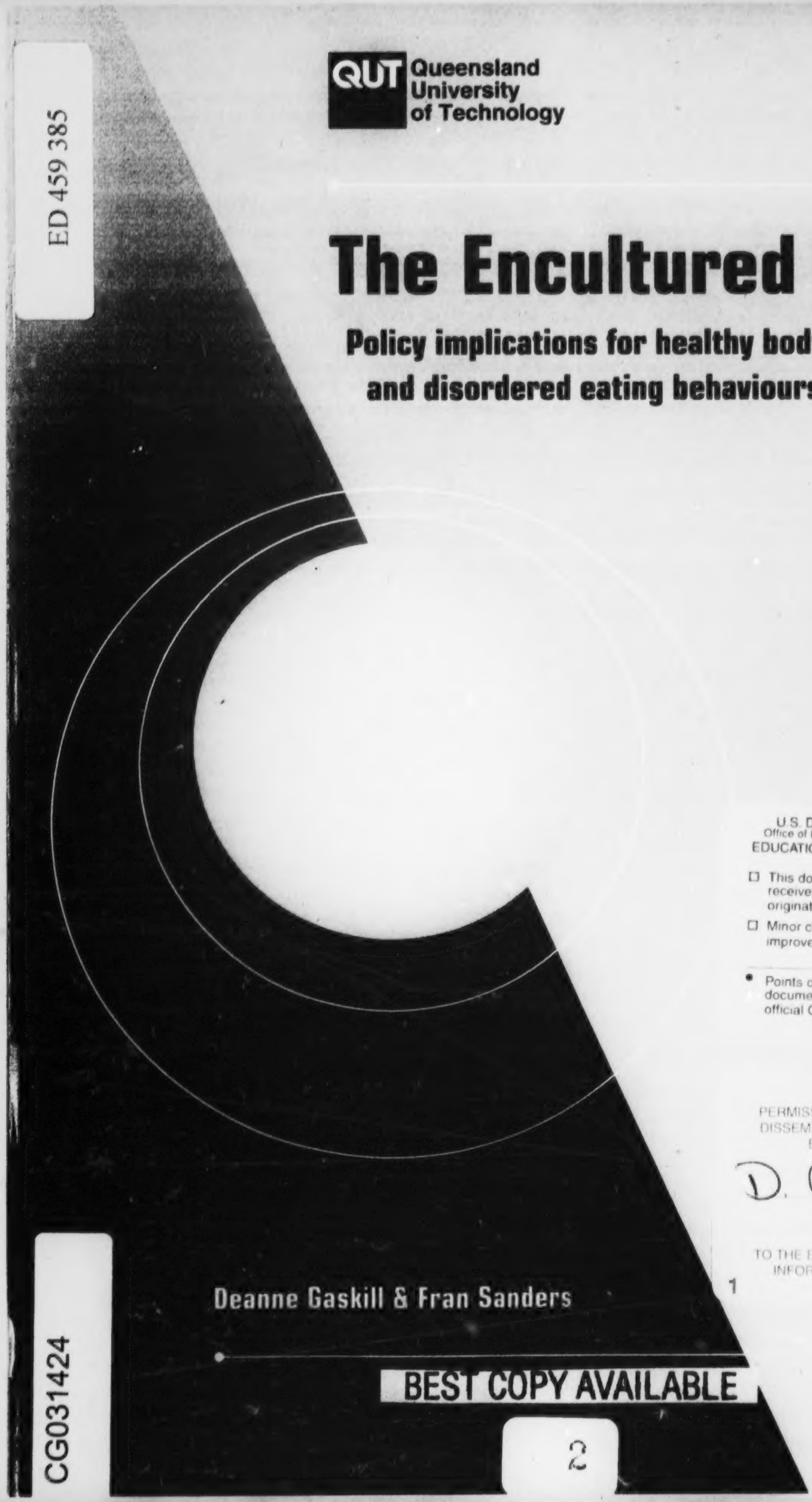
The Encultured Body:

Policy implications for healthy body image and disordered eating behaviours



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THE ENCULTURED BODY:

Policy Implications for Healthy Body Image and Disordered Eating Behaviours

Edited by
Deanne Gaskill and Fran Sanders

School of Nursing
Faculty of Health
Queensland University of Technology
http://www.hlth.qut.edu.au/

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Foreword

Eating disorders are a blight on our so-called emancipated, western world. Young women who in the last century have been freed from the prisons of traditional and restrictive dress, liberated from the oppressions of menstrual and reproductive functions, re-created through education and sporting opportunities, and for whom life begins to have a semblance of equality with their brothers, are struck down and taken back to 'square one' by these disorders.

At the coal face of adolescent existence, young women are now perhaps, under more pressure than ever before because the choice is so great, and because the potential of success is large and lifelike. Maybe that 'potential' looms over their heads as a threatening cloud rather than a glorious hope.

Whatever the aetiology, young women are now plagued with the risk of eating disorders. Young lives are destroyed or significantly impaired for long periods. Families, schools and health care providers alike are torn and hurt through different processes of despair, frustration and helplessness. Why, what, and how are the cries of pain – prolonged over time and expressed at least intermittently without hope.

This book, through a variety of talented, thoughtful and sensitive experts as authors, describes the conditions, considers risk and prevention, and reflects on the issues of socio-cultural influences and the media (such as *Barbie* magazine, lycra sports wear and cosmetic surgery) in the construction of these disorders.

Part III of the book deals extensively with treatment urging a multidisciplinary perspective and a wellness (whole of person) approach. The everyday anguish, frustration and struggle of those who live with these disorders (whether as sufferer, parent, sibling or partner) as presented in Part IV, leave the reader with no escape from the reality of the problem. One cannot consider this to be simply a theoretical matter to be debated and argued in the halls of learning, but rather, a pressing social and public health issue that everyone must face and for which we must strive to find solutions.

In so far as the very existence of these conditions may relate to the ways in which we have constructed society, the solutions will be far from simple. But face them and deal with them we must if the suffering and cost inflicted on individuals, families and our social institutions are to be minimised or eliminated.

This book is a valuable resource to everyone in the community but is especially important for those individuals who want to, or who by virtue of their work need to better understand these conditions, those who suffer them, and the society which allows them to happen.

Dr Cherrell Hirst
Chancellor
Queensland University of Technology
August, 2000

Preface

Background

The purpose of this publication is to provide discussion of some of the most difficult and controversial issues surrounding body image and eating disorders, specifically, anorexia nervosa and bulimia nervosa. This area constitutes a major and growing public health issue, and it is envisaged that the publication will act as a catalyst for wider consideration and policy development. Body image and its associated health, social, family and commercial concerns and interests are issues that cut across the everyday lives of most individuals.

The first Australasian body image and eating disorders conference: *Challenge the Body Culture: Attitudes, Acceptance and Diversity into the 21st Century,* was held in Brisbane in September 1997. Funding was received from Mental Health Branch, of the then Commonwealth Department of Health and Family Services to produce the Conference proceedings and to prepare a report containing recommendations from the Body Culture Conference for consideration towards development of the Second National Mental Health Plan. Both the Conference Proceedings and Report: *Challenge the Body Culture: An Exploration of Body Image and Disordered Eating Issues* were completed in February/March 1998.

This volume broadens the scope of the original report by including contributions from a number of nationally and internationally recognised clinicians and researchers in the field. It also incorporates valuable contributions from community workers and consumers associated with body image and disordered eating issues.

Interested readers are likely to be representative of individuals and organisations with a broad range of interests and involvement in the areas of body image and eating disorders. This includes medical, allied health and education professionals, as well as community organisations, the media, fitness and fashion industries, and government departments.

Organisation of the Book

The volume is divided into four parts.

Part I: Challenging the Body Culture.

Chapter 1, Body Image and Eating Disorders: Implications for Policy, is a distillation of contributors' reflections and recommendations for action for both the present volume and from the Conference. We trust that you will find these recommendations both realistic and, on occasions, controversial.

Chapter 2, Overview of Issues Related to Eating Disorders, is primarily concerned with introducing the reader to issues associated with body image and disordered eating behaviours and includes reference to a number of papers presented at the Challenge the Body Culture Conference. Information relates to prevalence data, sociocultural perspectives of eating disorders, treatment issues, in-patient data and associated costs, attitudes of health professionals, and frameworks for intervention related to eating disorders such as the Ottawa Charter for Health Promotion, and the Mental Health Intervention Spectrum for Mental Disorders (Mrazek & Haggerty, 1994).

Part II: Social Factors and the Body Culture, deals with issues related to socio-cultural concerns; media, cosmetic surgery and other emerging issues related to body culture and eating disorders.

Part III: Treatment Issues – A Multidisciplinary Perspective, discusses the treatment of eating disorders from a number of clinical perspectives, such as psychiatry, nutrition, psychology, nursing, General Practice and motivating change in clients.

Part IV: Community Voices, presents material relating to 'at-risk industries'; community organisations; and personal stories and poems of 'lived experience' as a sufferer, partner, parent or sibling. Personal stories and poems have been reproduced from selected, community group newsletters and professional meetings as a means of offering insight into the personal world of eating disorder sufferers, carers and friends.

The Epilogue encapsulates the tragedy and frustration of the many families, carers and professionals who have been touched by this public health issue.

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Dr Susan Paxton, Psychology Dept, University of Melbourne
Linda Pettigrove, Mental Health Branch, former Commonwealth Department of Health & Family Services
Rowena Plant, Eating Disorders Association – Queensland
Dr Jacinta Powell, Division of Psychiatry, Royal Brisbane Hospital
Leanne Wells, Mental Health Branch, former Commonwealth Department of Health & Family Services

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The Contributors to this extended edition, for their willingness to meet impossible deadlines.
Tina Thornton, Academic Editorial Services.

About the Contributors

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Professor of Psychology and Director of the Clinical Studies Program in the Department of Psychology as well as Clinical Associate Professor in the Department of Psychiatry at the University of Hawaii. She obtained her doctorate in clinical psychology from the University of Minnesota. Her principle areas of research and clinical interest are the eating disorders and cognitive behavioural theory and therapy. She has published widely in these topic areas and given numerous keynote addresses and workshops in the US, Canada and Europe. She holds positions on the editorial boards for the *International Journal of Eating Disorders* and the *Journal of Abnormal Psychology*. Professor Vitousek was a keynote speaker at the *Challenge the Body Culture Conference*. Brisbane, 1997. Her paper has been reproduced in this edition.

Pierre (Peter) Joseph Victor Beumont

Professor of Psychiatry, Department of Psychological Medicine, University of Sydney. Head of Department, 1975-1989 and 1991-1998

Areas of special interest include eating disorders, nutrition, neuroendocrinology and adolescent psychiatry. Professor Beumont is internationally recognised in the field of eating disorders and has contributed as editor and author to a number of definitive texts as well as a broad range of respected journals.

Deanne Gaskill

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Deanne's first involvement in this area, was through the approach by a group of carers and individuals with an eating disorder to assist in bringing the issues to the attention of government and the general community. Since then, Deanne has been involved in a number of education, community and research activities associated with body image and eating disorders. Her professional interests broadly reflect community mental health issues and consumer advocacy. Deanne was a member of the Organising Committee for the *Challenge the Body Culture* conference in Brisbane in 1997.

Elizabeth Gwynne

Elizabeth is a psychologist with a private practice in Brisbane specialising in eating issues and disorders, particularly amongst young women. She has been a member of the planning committees of several Queensland and national conferences on body image and eating issues, as well as advisory committees for Education Queensland and Queensland Health. In addition, she has undertaken quantitative and qualitative research on body image and eating issues with young women in Queensland secondary schools. Elizabeth was a member of the Organising Committee for the *Challenge the Body Culture* conference in Brisbane in 1997.

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Maureen has nearly 20 years experience working with eating disorders as a clinical dietitian both as part of a multidisciplinary team in specialist units in the public and private hospital systems, and presently in private practice. She has been involved in research looking at the nutritional management of bulimia nervosa, and has published a number of papers in this area. Her main area of interest at present is in improving the training of dietitians to better deal with eating disordered clients.

Peta Marks

Project Manager NSW Eating Disorder GP Shared Care Project. Department of Psychological Medicine, University of Sydney.

Between 1995 and 1999, Peta was the Nurse Coordinator of the Missenden Psychiatric Unit Eating Disorder Program, Royal Prince Alfred Hospital, Sydney.

Her professional/research interests include: education of health care professionals, in particular, shared care concepts in psychiatry; the role of nurses in recovery of patients with anorexia nervosa; the expanding role of mental health nurses in consultation, liaison, and as nurse practitioners.

Susan J. Paxton

Senior Lecturer, Psychology Department, University of Melbourne

Dr. Paxton is a psychologist with particular interest in body image dissatisfaction and eating behaviours in adolescent girls. Her clinical work is specifically with those who have eating disorders, while her research examines psychosocial contexts of body dissatisfaction, dieting behaviours and binge eating in non-clinical samples as precursors of clinical eating disorders, and evaluation of treatment options for bulimia nervosa. She is currently Deputy Chair of Body Image and Health Inc., Chair of the National Executive of the College of Health Psychologists, and Co-Convenor of the Psychological Treatments Sub-Committee preparing Clinical Treatment Guidelines for Anorexia Nervosa. Dr Paxton was a presenter at the *Challenge the Body Culture Conference*, Brisbane, 1997.

Anne Ring

After approximately eight years as Principal Research Officer at the Queensland Medical Education Centre (University of Queensland), while simultaneously working on her doctoral research on the dissemination of gender-linked health information in both the advertising and the editorial sectors of the mass media, Anne Ring has brought these areas of interest together in a variety of contexts. These include a recently completed University of Sydney development grant that involved teaching health professionals about health communications in the media, the provision of a pragmatic and media-oriented sociology of health care course to education students at James Cook University, and extensive research into the promotion of cosmetic surgery and related body image and medical practitioner issues. In this last area of work, Anne has established herself as an expert with a national reputation. She is, in addition, a writer on health, lifestyle, ageing and body image issues, with a number of publications in a variety of print media, and is on the panel of writers and editors for the Health Advisory Committee of the NHMRC.

Fran Sanders

Fran Sanders is a lecturer in the School of Nursing at Queensland University of Technology and for many years has specialised in community and public health and consumer issues. She became involved in the area of body image and eating disorders through the approach of a group of consumers almost ten years ago and this interest has continued. She has contributed to a number of education, research and community activities, including being one of three convenors of the *Challenge the Body Culture: Attitudes, Acceptance and Diversity into the 21st Century* conference in Brisbane in 1997.

Aline Smith

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Dr Smith has been a General Practitioner for 13 years. She has strong interests in paediatrics, adolescent and women's health issues. Her professional interests include being an active member of her local division of general practice for the past eight years, vice-chair in 1999, and GP coordinator of the Eating Disorders Shared Care Project for the Central Sydney Division of General Practice and the Royal Prince Alfred Hospital Eating Disorders Clinic. Dr Smith has also been providing general practice input into the NSW GP Eating Disorders Shared Care Project which aims to train and upskill GPs state wide in the treatment of patients with eating disorders.

Lois Surgenor

Lois Surgenor is Lecturer in Psychological Medicine at the Christchurch School of Medicine, University of Otago, New Zealand, and Senior Clinical Psychologist at the Christchurch Eating Disorders Service. She is convenor of the Clinical Indicators Subcommittee generating Clinical Practice Guidelines for the Treatment of Anorexia Nervosa on behalf of the Royal Australian and New Zealand College of Psychiatrists. She teaches postgraduate courses in eating disorders and psychotherapy, and her special research and clinical interest is in the area of anorexia nervosa.

Chris Thornton

Chris Thornton is a psychologist who has ten years experience in the treatment of eating disorders. He is currently the Clinical Director of Eating Disorders Day Programs at Wesley Private Hospital in Sydney. He is co-convenor of the Psychological Treatments Subcommittee generating Clinical Practice Guidelines for the Treatment of Anorexia Nervosa on behalf of the Royal Australian and New Zealand College of Psychiatrists. His current research interests are into the outcome of day treatment for patients with eating disorders and the use of Dialectical Behaviour Therapy in patients with eating disorders and Borderline Personality Disorder.

Helen Waite

At the time of the *Challenge the Body Conference*, Brisbane 1997, Dr Waite, a sociologist, was a lecturer at the University of New England. One of her two presentations at the Conference has been reproduced for this edition.

Glenn Waller

Professor Waller directs the Clinical Psychology Training Course at the University of Southampton, UK. He has published research on a wide range of issues in the field of eating disorders. He also provides clinical services to anorexia and bulimia sufferers. Professor Waller was a keynote speaker at the *Challenge the Body Culture Conference*, Brisbane, 1997. His paper has been reproduced for this edition.

Eleanor Wertheim

Associate Professor, School of Psychological Science, La Trobe University.

Dr Wertheim lectures, supervises and conducts research in the professional psychology training programs (Clinical and Health Psychology) at La Trobe University. For the past 13 years her research has focussed on eating disorders, eating behaviours and body concerns. Publications have covered the areas of bulimia nervosa treatment efficacy and predictors of outcome, research into the prevalence, correlates and predictors of unhealthy weight loss behaviours and body dissatisfaction in adolescents, and longitudinal research examining risk factors and the developmental course of disordered eating. Dr Wertheim's most recent research involves developing interventions to prevent the onset of eating disorders and disordered eating.

Hazel Williams

Consultant Dietitian-Nutritionist, 33 Green Valley Avenue, St Ives NSW 2075

Hazel Williams has specialized in the nutritional management of eating disorders for 21 years. She has worked in specialist eating disorder units in public and private hospitals in Sydney, as part of a multidisciplinary team. She has worked with inpatient and day patient programs, and currently in an outpatient clinic (the Metta Clinic, Pymble). Hazel has been involved in research projects looking at the nutritional intake and abnormal eating behaviours of anorexic patients and has contributed to chapters and articles on the nutritional management of eating disorders in many publications. She has been a co-presenter of seminars and workshops to train dietitians in the management of eating disorders.

Note

A number of the contributors to Part IV declined the offer to incorporate their biographical details in this section; consequently, all have been omitted.

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Part I: Challenging the Body Culture

Our culture, in which females lack power in comparison to males, and which endorses an attitude that female beauty is dependent on a very slim build, appears to put females at risk of disordered eating (Paxton, Chapter 3)

Chapter 1 – Body Image and Eating Disorders: Implications for Policy

Fran Sanders & Deanne Gaskill

This volume has drawn together a diverse collection of contributions from academics, clinicians, community workers and consumers. It is intended not to provide exhaustive coverage of the topic, but to present a range of perspectives and raise critical issues for discussion and consideration. The way forward must involve all stakeholders and develop out of wide public discussion. After all, there are few health issues that affect such a large percentage of the population as our society's concerns about body image and the impact of those concerns. It is also a health issue of national public health significance. Therefore, a national approach, coordinated with state initiatives is crucial.

A number of contributors have made specific recommendations for action and these fall mainly into three areas: firstly, issues of treatment and the delivery of treatment services from acute to rehabilitative; secondly issues related to health promotion at individual and societal levels, disease prevention and early detection; and thirdly, issues related to education. These are incorporated in the discussion below.

Treatment

The availability and quality of treatment services is an issue of ongoing concern to sufferers of eating disorders and their families. The major threads of these concerns include difficulty in accessing appropriate services and professionals, particularly outside of cities, the cost of private services, and the resulting lack of choice for consumers. Similarly, health professionals express concerns about limited resources, a lack of professional support, and the need for quality research upon which to base their interventions.

Many young people developing problems with eating and associated behaviours are reluctant to seek help because of shame or fear, or just do not accept that they have a problem. When they do consult a health professional, often at the urging of parents, it is usually the General Practitioner they go to. Unfortunately, evidence from community organisations suggests that GPs often do not recognise the danger signs, or may trivialise the problem. Thus the opportunity for early intervention is lost and the person is often seriously ill by the time they again seek assistance. It is vital that Government and professional associations implement educational activities and develop support resources and networks to ensure that all medical doctors, especially GPs, are able to recognise eating disorders and provide appropriate treatment or referral for patients presenting with these disorders (see Beumont, Chapter 10). Anorexia nervosa is of particular concern in this context (see Beumont, Chapter 10), although sufferers of other disorders also require appropriate intervention as early as possible. Early detection strategies also need to be implemented in schools through appropriately trained personnel such as school nurses and counsellors.

The issue of the education of all health professionals working with eating disordered clients is an important one. Studies have shown that as a group, these clients are among the least liked by health professionals (see Sanders, Gaskill & Gwynne, Chapter 2). Studies have also shown that the development of a quality therapeutic alliance between health professionals and eating disordered clients is a critical factor in recovery. Understanding the experiences of these clients from their perspective is a necessary part of developing the skills and attitudes necessary to work effectively with them (see Bemis-Vitousek, Chapter 11). Hospitalised sufferers and their families commonly report difficulty in developing positive relationships with staff whom they often see as judgmental and punitive. Professionals need to accept that this is a real issue, and education programs need to extend beyond the information and skill level to address attitudes.

The development of 'centres of excellence' in the treatment of eating disorders has received considerable attention in recent times, and some health authorities have developed these within their jurisdictions. However, such centres alone are not able to meet the treatment needs of sufferers. Rather, some authorities are arguing for a shift from a focus on treatment in specialist centres to the development of a periphery or network of excellence that includes community health clinics, day-hospital units, and collaborative, shared care programs with general practitioners (see Beumont, Chapter 10). Such a model would utilise existing services throughout the country, develop the skills of practitioners in a range of services rather than in a few isolated sites, and facilitate the availability of high quality treatment in local areas where sufferers live. The use of communications technology could enable the development of networks of services linked with centres of excellence and each other, to allow professional consultation and backup for clinicians in isolated areas, and multidisciplinary input across regions (see Marks, Chapter 13).

Integrated services which can meet the needs of eating disorder sufferers across acute episodes requiring hospitalisation and ongoing treatment in the community and which can provide ready access for all patients requiring treatment are urgently needed. Their establishment should be a priority of State health authorities (see Beumont, Chapter 10). To assist integration between in-patient services and management in the community the person or their family (if a minor) could be encouraged to nominate a general practitioner early in their in-patient or outpatient program and that GP could maintain a shared-care role with the acute service. There are also problems at times with adolescents from approximately 16 to 19 years who 'fall between' adolescent and adult services (see Smith, Chapter 15). Better integration between these services could assist.

The treatment needs of severely compromised anorexia nervosa sufferers can pose particular problems. If the person is in a critical state, but refuses treatment, he/she must be regulated under the Mental Health Act. Some new form of legislation which steers a middle path between excessive compulsion (regulation) and medical neglect (failing to treat the person) is required to protect psychiatrically disturbed eating disorder sufferers from the dangers posed by their illness (including possible death). This legislation should be different from that providing for the needs of other patients who require regulation because they are a danger to themselves or others (see Beumont, Chapter 10).

Health professionals working in the eating disorders field are often isolated. Systems of multidisciplinary group and individual clinical supervision and peer review need to be available to all professionals working in this area (see Surgenor & Thornton, Chapter 12; Marks, Chapter 13). Telemedicine and teleconferencing facilities linked with major treatment centres could be investigated as an avenue for the provision of clinical support for medical and other personnel in rural and remote areas. To enhance treatment provision a team approach whereby the skills of various disciplines could be appropriately utilised in the best interests of both patients and service providers needs to be developed (see Marks, Chapter 13). Such teams could link networks of both public and private providers.

Clinical practice guidelines developed by authoritative clinicians with contributions from all legitimate stakeholders, including general practitioners, physicians, paediatricians, psychologists, nurses, dietitians and, importantly, consumers and carers must be developed (see Surgenor & Thornton, Chapter 12; Beumont, Chapter 10). Guidelines for the treatment of anorexia nervosa have now been commissioned by the Royal Australian and New Zealand College of Psychiatrists (see Beumont, Chapter 10). However, similar guidelines are required for the treatment of other eating disorders, particularly bulimia nervosa.

Research is urgently needed to demonstrate the effectiveness of various treatment modalities. Still today, the outcomes for many patients, even those treated by experts, is of grave concern. More sensitive and appropriate outcome measures than those existing, which include issues such as nutritional state and quality of life are required (see Beumont, Chapter 10). As there is evidence to suggest that Cognitive Behavioural Therapy is an effective treatment for bulimia nervosa and body image disturbance it should be continued for those suffering from this disorder, but should be further researched (see Surgenor & Thornton, Chapter 12).

It is critical that people suffering eating disorders receive treatment from health professionals with relevant clinical education, registration and specialist knowledge to allow the best possibility of success (see Surgenor & Thornton, Chapter 12). Education and professional networking programs could enhance professionals' skills, and provide skilled supervision, particularly for new practitioners.

Some practitioners and programs still place emphasis on weight gain and other symptom resolution, but pay little if any attention to the need for sufferers to resolve underlying issues which have contributed to their development of dysfunctional eating behaviours. A more holistic approach to treatment is required, which attends not only to symptom resolution, but to assisting the individual to deal with personal, family and social issues. Support and assistance for families of sufferers should also be included in this holistic approach. A broader range of treatment options should be made widely available through a number of avenues including counsellors, psychologists, and community organisations. A further issue is the unavailability of Medicare rebate for services provided by a number of professional disciplines, well qualified and skilled to provide treatment options for eating disorder sufferers. This should be reviewed as a matter of urgency. Service cost is a major inhibiting factor for many sufferers in obtaining the treatment of their choice (see Surgenor & Thornton, Chapter 12).

Prevention

Considerable activity has taken place in the area of prevention during the last few years with mixed results. Overall, there have been problems with the adequacy of evaluation of programs, little evidence that they are effective and some evidence that in some circumstances they may actually be harmful. Nonetheless, getting it right is important and if effective prevention interventions can be identified, savings in human and dollar terms are possible.

It is also vital to broaden thinking about prevention beyond a focus on individuals who may be at risk, to addressing the numerous structural issues which contribute to the prevailing climate of unhealthy attitudes about body image and food (see Paxton, Chapter 3). The community as a whole is bombarded with negative messages about body image and the various products and interventions advocated to 'fix' dissatisfaction with appearance. This has been mostly aimed at women, but men are also becoming targets (see Ring, Chapters 5 and 8). Because of the enormous profits involved in the industries promoting these negative attitudes, this area is particularly sensitive, and comes down to a trade off between public good and corporate profit. Areas in which children are the targets of such marketing should be of utmost concern to governments and health authorities (see Sanders, Gwynne & Gaskill, Chapter 7).

The Mental Health Promotion and Prevention National Action Plan, under the Second National Mental Health Plan 1998-2003, identifies targets in relation to promoting healthy body image, reducing risk factors for eating disorders, reducing the incidence and prevalence of eating disorders, and researching the effectiveness of prevention programs in relation to children, youth and young adults. However, the focus is largely upon directing interventions at individuals, to do things such as improve their self esteem, provide them with the ability to decode and interpret media messages, or improve their knowledge about healthy lifestyle and diet. While these are probably helpful for some, it could be argued that the overwhelming counter influences from media, advertisers, fashion, cosmetic and diet industries make interventions directed at young people without some form of Government intervention in the practices of these industries largely a waste of resources. Of particular concern is the way in which children are regarded as a legitimate target for the marketing of a range of products including fashion, cosmetics and toys, which reinforce gender stereotypes and create the belief that acquiring particular products will result in happiness. Regulation in this area is almost non-existent and requires urgent attention.

Avenues for action by government authorities against the promotion of unhealthy messages about weight control, dieting, body size and image, and the use of cosmetic surgery, need to be investigated as a matter of urgency (see Beumont, Chapter 10). This would include media of all sorts, the fashion and cosmetics industries, weight loss and gym industries, and the cosmetic surgery industry. Some authorities argue that regulation is the only way in which change will be effected (see Waller, Chapter 6). The continuation of activities which nourish the current negative social climate within which body image concerns and eating disorders are developing is unacceptable, and a continual drain on prevention and treatment resources. Prevention is not only about individual's attitudes and behaviours, but about creating a healthy social environment in which there is no place for the current questionable activities of various corporate enterprises. Self-regulation has failed and other avenues must now be considered.

A systematic program of research into prevention interventions, involving long term evaluation, examination and comparison of specific components of programs, and identification of the circumstances and characteristics of participants and how these link with the impact of prevention strategies is required. Programs for skills development for appropriate personnel and organisations interested in providing prevention programs are also required (see Wertheim, Chapter 4).

Resourcing successful prevention interventions on a national scale would then need to be investigated and planned for (see Wertheim, Chapter 4). Approaches are required to address the current lack of awareness and care taken by influential adults about the development of positive self-esteem and healthy attitudes towards eating and weight amongst children. Children absorb the attitudes of the adults around them from a very early age, and negative or obsessive attitudes on the part of adults, about body size, shape, diet and eating are quickly communicated. Action needs to be taken to counteract the extreme anti-fat phobia in society so that a healthy, rewarding and balanced lifestyle is valued above a particular appearance.

Education

Education and awareness raising around these issues is of concern for the community as a whole, for individuals and families facing problems, and for health professionals. Few of the health disciplines whose practitioners commonly treat eating disorder sufferers receive significant education about these disorders in their undergraduate preparation. In addition, there are few opportunities available to undertake post-graduate or specialist courses (see Surgenor & Thornton, Chapter 12; Marks, Chapter 13; Williams & O'Connor, Chapter 14; Smith, Chapter 15). There is also a need for public education about body image issues, eating disorders and healthy attitudes to food.

A range of strategies for ongoing education of the general public about the seriousness of eating disorders such as anorexia nervosa, and associated unhealthy attitudes and behaviours surrounding dissatisfaction with body image, are needed. Extreme weight-loss activities should be acknowledged as dangerous risk-taking behaviour, similar to the abuse of narcotic drugs, unprotected sex, and drink-driving (see Beumont, Chapter 10).

The inclusion of in-depth education about the eating disorders within the undergraduate education of all relevant health professionals should be negotiated between health and relevant educational authorities. Opportunities for continuing and post-graduate education for all professionals working with eating disorder sufferers also need to be developed. The development of resources for the use of health professionals should include information on the disorders and their effects, and directories of services and professionals providing treatment for eating disorders on a regional basis (see Smith, Chapter 15). The service directories in particular could also be available to consumers. However, the issue of currency is a difficult one in the case of directories, and investment in Web sites may be more effective as access becomes more common across the community.

A national register of therapists and treatment centres could be established and a national eating disorders web site to promote information exchange, networking, access to research, and communication between consumers and professionals developed (see Williams & O'Connor, Chapter 14).

Schools are a vital area in terms of providing prevention, support, or early intervention activities. A huge responsibility falls onto teachers and specific education programs need to be developed to enable them to participate in and support school initiatives and respond appropriately to students experiencing problems. Others working with young people through roles such as in community organisations, the arts, sport and recreation, also need education about these issues.

Taking a new approach

It is clear that there is much to be done to improve the situation in relation to the prevention and treatment of eating disorders, the education of professionals and the community, and the conduct of research into all aspects of these disorders and associated issues. However, the need is urgent, and progress through conventional means alone is often slow.

One could draw an analogy with the HIV/AIDS area. Some years ago, those involved rejected reliance on experimental research designs because they took too long to produce results. People were dying and the need for quick results was pressing. Action research approaches were implemented through which the people most affected were seen as a major source of ideas and solutions. Could innovations such as needle exchange programs have developed from traditional research approaches?

Whilst traditional methods have an important place in eating disorders research, other approaches are needed. Perhaps it is time to seriously employ action research and other qualitative methods in this field. Go to the people, learn from the people.

Chapter 2 – An Overview of Issues Related to Eating Disorders

Fran Sanders, Deanne Gaskill and Elizabeth Gwynne

It is now widely recognised that in Western countries, including Australia, eating disorders, diagnosable on DSM-IV criteria (American Psychiatric Association, 1994), and a range of disordered eating behaviours, are affecting increasing numbers of people, especially girls and young women. The realm of eating disorders is extremely complex and multi-factorial. In relation to these disorders, aspects of mental and physical health and personal or spiritual well being converge in a way that is unique. As Fontaine (1991) states:

> *Eating disorders are not simply a matter of eating too much or too little. It is in the complex interaction of biologic, psychological, developmental, familial, and sociocultural factors that vulnerable people develop eating disorders* (p. 669).

Although anorexia nervosa was first described as early as the 17th century (Biley, 1989), bulimia nervosa was first documented in the 1940s. Anorexia nervosa is characterised by severe weight loss, usually over 25% of normal body weight, fear of fatness, low self-esteem, extreme dieting behaviours, distorted perception of body shape, and amenorrhoea. Bulimia nervosa sufferers also have a great fear of fatness, but their disorder is characterised by binge eating followed by purging, vomiting and fasting. They are not necessarily underweight.

Health consequences

Many serious health and social consequences result from eating disorders. Some suggest that anorexia nervosa, in its chronic state, has a mortality rate between 10% and 20% (Tolstrup, Brinch, Isager, Neilsen, Nystrup, Severin & Olesen, 1985), with suicide as the commonest cause of death overall (Treasure & Szmukler, 1995). This is one of the highest mortality rates for any psychiatric disorder (Powers, 1995) and is further elaborated upon in Chapter 10. Although the mortality rate for bulimia is much lower, if untreated, it too can become chronic. The physiological complications of both disorders are substantial and include amenorrhoea, infertility, osteoporosis, cardiac arrhythmia, electrolyte disturbances, loss of normal peristaltic and sphincter functioning, dental decay, malnutrition, hair loss, changes in body temperature, slowing of metabolic function, impaired cognitive functioning and fatigue. Depression, anxiety, obsessive tendencies and affective instability are also common (Gibbons, Wertheim, Paxton, Petrovich & Szmukler, 1995; Rosen, Gross & Vara, 1987).

However, as Robertson (cited in Garrett, 1995, p. 8) points out, the label and definition of anorexia nervosa: *was created by the medical profession in an attempt to explain, study and control behaviour which they could not understand.* In so doing, psychiatry has actually created an illness called anorexia nervosa, replacing the changing and culturally determined behaviours which used to be referred to as 'anorexia mirabilis' (miraculous or saintly fasting).

Prevalence and associated behaviours

Although there is great variation in prevalence rates cited in various sources, according to strict clinical criteria, it is generally estimated that 2% to 3% of females past the age of 13 years satisfy the DSM-IV diagnostic criteria for anorexia nervosa or bulimia nervosa (American Psychiatric Association, 1994; Clayer, McFarlane, Bookless, Air, Wright & Czechowicz, 1995; Ben-Tovim, Subbiah, Scheutz, & Morton, 1989; Ben-Tovim & Morton, 1989), with women constituting around 90% of the eating disordered population (Leal, Weise, & Dodd, 1995; Striegel-Moore, Silberstein & Rodin, 1986). Australian incidence rates are consistent with those of other industrialised countries. However, these figures are likely to be conservative. Because of the shame many sufferers experience, or their failure to recognise that their eating behaviours constitute a serious health problem, many do not present for treatment. In addition, incidence rates fail to include the considerable proportion of women and girls who do not meet diagnostic criteria, but engage in weight loss or weight control behaviours which are damaging to their health and diminish their feelings of self worth and well being (Huon, 1994; Mintz & Betz, 1988; Paxton, Wertheim, Gibbons, Szmukler, Hillier & Petrovich, 1991; Rosenvinge & Borresen Gresco, 1997). Sufferers of these various forms of disordered eating behaviours share the same attitudes and concerns about food, body weight and size, but do not develop the same, or such severity of symptoms, as the anorexia sufferer (Patton, 1992). Whilst the incidence of anorexia has remained relatively stable, there has been a dramatic increase in the incidence of bulimia during the past 20 years (Rolls, Federoff & Guthrie, 1991) and an even more dramatic increase in the numbers, particularly of young people, exhibiting some bulimic symptoms. It is becoming extremely common for adolescent girls to go through a phase of dieting, often associated with other weight control behaviours such as purging or using diuretics and laxatives. These trends are likely to continue, leading to an increase in people experiencing problems with eating behaviours and presenting to health services for treatment. In addition, between 30% and 50% of anorexia sufferers will develop symptoms of bulimia during the course of their illness (Johnson, Lewis & Hagman, 1984). The morbidity associated with disordered eating behaviours, including eating disorders, has emerged as an important and growing public health issue which requires a range of strategies aimed at community and individual levels.

Pike (1995) proposed that *the clinical population represents just the tip of the iceberg, and that subclinical manifestations of* [eating disorders] *are extremely common amongst adolescent girls* (p. 374). Findings from Australian studies support Pike's argument. Paxton et al. (1991), in a study involving 341 female and 221 male high school students in Victoria, found that 47.9% of girls and 26% of boys occasionally used at least one extreme weight loss measure, and 13.2% of girls and 8.8% of boys used such a measure weekly. Further, 3.5% of girls and 1.5% of boys, used more than one measure weekly. Between 4% and 5% of respondents used smoking to lose weight on a weekly basis. Extreme weight loss measures were defined as fasting, crash dieting, vomiting, and using diet pills, laxatives or diuretics. Cosmopolitan Magazine conducted a community based survey of their young Australian readers involving over 2,000 respondents, two thirds of whom were aged between 16 and 29. Results showed that 60% thought they were overweight although only 23% actually were, according to weight for height norms; 50% were unhappy with their bodies; 13% had been on ten or more diets in the past three years; and 30% were more worried about their weight than anything else. Weight loss behaviours used by respondents included skipping meals (50%), smoking instead of eating (21%), using diet pills or laxatives (27%), and 18% reported vomiting after eating (Junker, 1997). The Australian Women's Longitudinal Health Study which commenced in 1996 (Kenardy, 1998) has identified that dieting behaviour is common amongst young Australian women aged between 18 and 22 years (total of 14,459 respondents), and is linked with body dissatisfaction, and disordered eating patterns. Forty eight percent (n=6,180) of participants had dieted to lose weight within the previous year and of these, 12.2% (n=1,582) had dieted five or more times within that year. Further, approximately one in four (23.7%) in this age group had fasted to control their weight or shape; 13.6% had used vomiting, 9% had used laxatives; and 3.5% had taken diuretics (J. Kenardy, personal communication, January 1998).

Risk Factors

Various risk factors for the development of eating disorders are identified in different studies. Leon and colleagues (Leon, Fulkerson, Perry & Early-Zald, 1995), in a prospective study of 852 girls and 815 boys, found *that the strongest predictors of concurrent eating disorder risk status were body dissatisfaction (unhappiness with body shape and size)* (p. 141), along with high reactivity to stress and poor emotional awareness. A history of dieting is a frequently identified risk factor (Hsu 1989). Current views are that a number of factors are implicated in the development of eating disorders including the cultural emphasis on slimness, the impact of the media, stress, the role confusion and poor self image associated with adolescence (Hsu, 1989), and low self esteem. This same author believes that eating disorders are increasing because more women are dieting in pursuit of the thin ideal, and that as dieting combined with other factors leads to eating disorders, it is inevitable that some of these dieters will develop these disorders. This factor has also been identified in relation to boys. It is speculated that as dieting is increasingly practised by boys and men, so the incidence of anorexia in males will increase (Wolf, 1990; Garrett, 1992). Norwegian writers Stoylen and Laberg (1990) take the view that *the current emphasis on unrealistic slimness has more to do with the aetiology of anorexia and bulimia than any other single factor* (p. 52). For an exploration of risk factors, see Chapter 3.

Our society generally holds very negative attitudes towards fatness which are probably more about appearance and stereotypes of attractiveness rather than concerns about any threat to health of being overweight. People identified by society as overweight suffer discrimination, stereotyped attitudes, psychological consequences and the social sanctions of living in a society which values thinness as the ideal body size. Issues of size discrimination were addressed in a symposium: 'Exploring attitudes and values towards body size' (O'Hara & Allen, 1998) at *the Challenge the Body Culture Conference*. Participants identified a range of strategies to change community attitudes and make public space and facilities more appropriate for the needs of people with a range of body sizes.

Requests to community organisations that provide support to women and youth further illustrate the extent of the problem. Figures from Kids Help Line (KHL) indicate that in two years, from January, 1998 until December, 1999, 1,236 calls concerning 'eating behaviours' (less than 1% of all calls) were received (KHL Statistical Summary - Eating Behaviours, 2000). For the purpose of their record keeping, KHL define eating behaviours as concerns from callers *specifically about their weight or behaviour surrounding eating. Callers with anorexia or bulimia, under/over eating and including behaviours such as the use of laxatives, appetite suppressants, obsessive exercise etc.* Overall, 96% of calls related to eating issues were made by females, nearly a third (30%) of whom were aged 10 - 14 years and two thirds (66%) 15 -18 years. Nearly half of these calls (42%) related to young people who *reported engaging in continued disordered eating behaviours with an additional 8% (96) of callers stating they were experiencing a severe health problem due to their eating behaviours* (KHL, 2000). KHL counsellors note that callers *often cite family problems, bullying from peers, child abuse (physical and sexual), low self-esteem and self-image problems as issues underlying their problem.* Other issues that have been mentioned include sexual assault, pressure related to study, pressures from family to lose weight, and athletic performance.

Two Brisbane based services, (i) ISIS - Centre for Women's Eating Issues, responded to about 800 contacts from young women in 1997 (personal communication, Catherine Black, October, 1998), while (ii) the Eating Disorders Association - Qld Resource Centre received approximately 1,500 phone calls per year (since 1997) and in excess of 40,000 visitors per year to its website (see Chapter 19 and Powell & Fleming, 1999).

Dieting is considered problematic for a number of reasons. A history of dieting, usually driven by a fear of becoming overweight or actual overweight status, is widely recognised as being a risk factor on the pathway to the development of an eating disorder (Hsu, 1989; Huon, 1994; Patton, 1992). Patton, Johnson-Sabine, Wood, Mann & Wakeling (1990), found that eating disorders were eight times more likely to occur in adolescents who dieted than in their non-dieting peers. Additionally, and contrary to claims of success by the weight loss industry, prolonged dieting is ineffective in terms of sustained weight loss. For example, Burgard and Lyons (1994) found that 90% to 98% of dieters either failed to lose weight, or gained additional weight in the long term. Prolonged dieting not only lowers the metabolic rate, thereby increasing the likelihood of weight gain even with normal eating, but also increases the dieters vulnerability to binge eating episodes. It is not uncommon to hear an obese person describe how they dieted their way to obesity (for example, Judith's story, In: Gaskill, Sanders & Gaskill, 1995, p. 35-36).

Most authorities agree that the causes of these disorders are complex, involving family, social, personality and psychological factors. Major risk factors for the development of eating disorders have been identified as a history of dieting, and low self-esteem (Button, Sonuga-Barke, Davies & Thompson, 1996), drive for high achievement (Thornton, Leo & Alberg, 1991), and teasing about appearance or size by peers or family (Thompson, Fabian, Moulton, Dunn & Altabe, 1991). In addition, the developmental changes associated with puberty, including change in body shape, weight gain, and a growing desire to appear attractive to the opposite sex, place adolescent girls at particular risk (Attie & Brooks-Gunn, 1989). The influence of peers through friendship networks may deter young people from becoming involved in disordered eating behaviours (Wertheim, Paxton, Schutz & Muir, 1997), or influence them to adopt such behaviours. Paxton (1998) suggests that peer influences must be considered in the development of health promotion programs.

There is clear evidence that media influences are a contributing factor in the development of eating disorders (Stice, Schupak-Neuberg, Shaw & Stein, 1994; Murray, Touyz & Beumont, 1996; Paxton, Schutz, Wertheim & Muir, 1996; Gwynne, 1997). The high value placed upon the thin body ideal, which is so pervasive throughout society, creates a social climate in which vulnerable people are further influenced in their desires to become thin. The thin ideal is continually promoted through all forms of the media, and influences children's attitudes from an early age. Evidence demonstrates that girls as young as five years are concerned about their size and weight and have a strong preference for a thin body size (Veron-Guidry & Williamson, 1996). Williamson and Delin (1998), reporting their research at the *Challenge the Body Culture Conference*, found evidence for the emergence of a slim ideal in Australian girls as young as five years of age. Girls acquire notions of feminine beauty at a very early age. Sex role identification begins before the age of two years and being a girl becomes linked with the requirement to be pretty. By the time girls reach puberty, activities aimed at enhancing attractiveness, principally for the purpose of finding a boyfriend, consume a large amount of the teenager's time and energy (Freedman, 1984). A number of studies have shown that attractive girls obtain more dates, and that unlike girls, boys consistently specify attractiveness as an important characteristic in a dating partner (Sobal, Nicolopoulos & Lee, 1995; Smith, Waldorf & Trembath, 1990).

Males and eating disorders

Until recently, there has been little pressure on men in Western societies to adhere to rigid standards of size or weight. It has been generally acceptable for men to be overweight, whilst overweight women have been the subject of considerable, negative social sanctions. However, there is now a growing focus on a muscular, fit, trim ideal for the male body, occurring alongside a burgeoning men's fashion industry. Whilst only one male is diagnosed with an eating disorder for every ten females, boys are also coming under increasing pressure about their appearance through the current, male role model image. Although girls have a thin body ideal, boys aspire to be strong and muscular. Waite (1998) has discussed the rise in 'muscular masculinity' particularly in sports men and film stars who provide popular male role models (see Chapter 9). Pursuit of such images can become associated with excessive body building and steroid use, creating another set of health problems stemming from poor self esteem and the pressures to conform to a socially created and marketed ideal. A number of authors suggest that as such pressures on men increase, the incidence of eating disorders and destructive behaviours such as excessive exercise, dieting and purging amongst men will also increase (for example Streigel-Moore et al. 1986).

Cultural factors

A limited number of studies have investigated transcultural factors in eating disorders. An example is an American study of black and white female college students (Abrams, Allen & Gray, 1993). The results confirmed the culture-bound nature of these disorders. It found that even though the white students were lighter, they were far more concerned with weight than the black students, undertook many more activities to achieve a thin body, and displayed more symptoms of eating disorders. The researchers found that there was a far greater range of acceptable body size and shape within the black culture than within the white women's culture, indicating different standards of beauty. White respondents' weight concerns were rarely related to actual weight problems, but rather to perceived weight problems. Black women who demonstrated greater weight concerns and restriction of food intake were those who had at least in part rejected their black identity. In both groups, disordered eating behaviours were associated with anxiety, depression and low self-esteem. In contrast, Lachenmeyer and Muni-Brander (1988) found not only high rates of such behaviours in adolescents, but also that *eating disorders cross socio-economic class and ethnic groups* (p. 303).

Although some writers argue against the significance of cultural factors in the eating disorders continuum, favouring biological and psychological explanations (for example, Steiger, 1993), there is accumulating evidence which supports the cultural argument, not as the whole explanation, but as a vital and complex contribution. Nasser (1988a) summarises some of the evidence: the higher incidence of the disorders in particular sub-cultures such as dancers and models; the Midtown Manhattan study which found that the longer immigrant women had been exposed to American culture, the lower their levels of obesity; a 1981 study by Worsley in which British Kenyans rated larger figures negatively, while Asian Kenyans rated them favourably; a 1983 study by Fichter which found a higher incidence of anorexia amongst Greek girls living in Munich than amongst Greek girls living in Greece; a rise in binge eating in Japan which the researcher linked to increasing exposure to American culture; and a higher incidence of bulimia amongst female Arab students in London, than amongst those in Cairo. In a related paper this author discusses attitudes to body weight and feminine beauty in a number of non-Western cultures. He refers to earlier authors who found that

> *...plumpness was considered attractive and desirable in the majority of societies, and obesity has even been considered in some cultures as a secondary sexual characteristic...in Arabic culture, thinness is regarded as socially undesirable, and plumpness is considered to be a symbol of fertility and womanhood...the Chinese too associate fatness with prosperity and longevity, and their Gods are always portrayed as fat...for a Punjabi Indian to be greeted with "you look fat and fresh today" is regarded as a complement* (Nasser, 1988b, p. 185).

In a study of the way in which Ugandan and British respondents rated the attractiveness and health of male and female body size images, Furnham and Baguma (1994), produced findings which supported previous research showing that the overall wealth of a country, region or ethnic group affects ratings of attractiveness. The greater the wealth of a group, the more desirable thinness becomes, whereas poorer people rate obesity as more healthy and attractive, as did the Ugandans in this study. The author proposes a couple of explanations for this result. Firstly, in poor countries, fat deposits mean that people will be better able to survive the times of hunger, and secondly, fatness is a sign of wealth, and as wealthy people can afford food and medical treatment, desirable.

Banks (1992) urges that the feelings and meanings that anorexia and bulimia sufferers themselves attribute to their behaviours and experiences, and to eating and the body, should be included in attempts to explain the causes of these disorders. She believes that current cultural explanations are limited as they ignore sufferers' conscious and unconscious meanings surrounding their experiences. She presents two case studies to illustrate her argument that for some women, there are deep religious meanings reflected in their attitudes to food and eating. Historically there is considerable evidence of women using fasting and food restraint for religious reasons, and Banks sees links between religious fundamentalist beliefs about the body, sex and food, and eating disorders in the contemporary context.

Treatment issues

Eating disorders are one of the few conditions that span the realms of physical, mental and social health. Further, their physical and psychological complications are at best, extremely serious, and at worst life threatening. Treating these disorders poses difficulties for all concerned and because many sufferers present to health services very late, attitudes and patterns of behaviour, as well as health complications are often entrenched.

Very few, comprehensive evaluations into the outcomes of treatment services for eating disorders have been conducted. One exception is the study by Strober, Freeman & Morrell (1997) who conducted a longitudinal study of 95 anorexia patients, 76% of whom had fully recovered after a ten to fifteen year follow-up period. Martin (1990) compared outcomes for a range of treatment approaches and argued that it was difficult to draw conclusions, as many of the programs had not been satisfactorily evaluated. There seems to be a lack of consensus amongst practitioners about the best treatment methods, particularly for anorexia. Some practitioners argue that cognitive-behavioural treatments for bulimia are most often successful and that the main difficulty for bulimia sufferers in Australia is gaining access to specialist services, particularly specialist psychologists (S. Paxton, personal communication, January 1998). However, in relation to anorexia there is more caution and this disease is seen as very difficult to treat.

In-patient treatment is successful in achieving weight gain but is usually traumatic for both sufferer and family, and in many cases weight is quickly lost again post-discharge. Currently, there are limited alternatives to behavioural approaches for acutely ill in-patients (J. Powell, personal communication, January 1998). Yager (1994) endorses 'psychological treatment methods' as most effective, but because there are no specific treatments for either disorder, advises an eclectic approach. Similarly, Touyz and Beumont (1991) argue that as there is a lack of research to clearly demonstrate the benefits of any particular treatment modality, therapists should take a broad approach rather than adopting any one strategy. There is no evidence that the behavioural approach, which involves deprivation of rights and privileges until the person co-operates by gaining weight, is effective. In fact this approach seems to create a revolving door syndrome in which the person gains weight to escape from confinement rather than because of any resolution of problems, and immediately begins dieting again following discharge. In support of a less rigid approach, Touyz, Beumont and Dunn (1987) report that the weight gains of 68 patients who received treatment through a more lenient and flexible behavioural program were the same as for a more rigid program. The authors state:

> *There is no justification whatsoever to implement harsh behavioural regimes to punish patients who have not complied with treatment up to that point in time. Tube feeding as a negative contingency should never be contemplated. We have not found the need for tube feeding in the treatment of over 500 patients with anorexia nervosa (p. 155).*

Another issue is that the process of re-feeding hospitalised eating disorder sufferers is often not followed with the implementation of appropriate therapy and there is a widespread lack of meaningful long term follow-up and support post discharge. These transitional needs are not adequately met under existing health care arrangements. These are serious gaps in services, and many of these clients are repeatedly re-admitted in the same or a worse state of debilitation. In addition, it has been suggested that moves to early discharge have resulted in some anorexia sufferers being re-admitted more quickly than previously and actually utilising more bed days and therefore more health dollars (J. Blair, personal communication, November 1997). However, further analysis is necessary to clearly identify trends in this area.

Clients, families and some practitioners and researchers have questioned the limited treatment options available for most sufferers. In addition, support and counselling for families is an area of need. Queensland Forum participants from a number of states expressed these concerns (Gaskill et al. 1995). This is an area in which a range of health professionals other than medical personnel have much to offer. At present, alternatives to medical treatment are very limited for most people because of funding arrangements. One community based service made the point that most young women accessing their services have a long history of contact with the medical system, with little success, and are seeking treatment or counselling options which can offer an alternative approach:

> *Currently the only counselling options for women are generalist counselling services (where workers often do not have the confidence or expertise to work in the area of eating disorders); mental health services (many of which will not see women who only have an eating disorder as their mental health issue – they require them to have a more "serious" mental health issue); psychiatrists (those who have expertise in the area have lengthy waiting lists or frequently only offer short consultations on a monthly basis); and other private practitioners such as psychologists, counselors/therapists and social workers (who many women cannot afford to access because of the medium to long term treatment usually required)* (C.Black, personal communication, January 1998).

On a limited basis, positive results are being achieved through support groups and therapy groups. With Queensland Health funding, *ISIS – Centre for Women's Eating Issues*, developed and documented a feminist model of group work for young women. Such approaches could offer an acceptable alternative for many women to address their eating issues at an early stage before they become serious enough to lead to the diagnosis of an eating disorder. Serious consideration needs to be given to avenues for more adequate funding in such areas.

Obtaining sensitive and effective treatment in rural areas is even more difficult than it is in the city. The training of General Practitioners would assist with this need. There is anecdotal evidence from sufferers and their families that currently many GP's do not want to treat acute eating disorder sufferers, or do not know how to appropriately treat people with an eating disorder. Whilst this problem is not unique to rural areas, the lack of other alternatives for rural clients can cause particular stress and suffering.

For clients who are privately insured, the minimal provisions for rebates often limits treatment or forces people back on the public hospital or medical systems. For example, the maximum rebate for psychology services is $250 to $300 annually. This does not allow for many visits, and successful treatment requires long term therapy which is not covered by the present rebate guidelines unless the person is treated by a psychiatrist. Therefore, in many cases, increased and more costly medical visits and hospitalisations are the result. At least some of this could be prevented if better arrangements were in place.

In-patient data and health care costs

It is clear that the costs of treating eating disorders, particularly for individuals who require admission to in-patient settings, are high. However, it is difficult to obtain accurate, and therefore, meaningful data about in-patient statistics (general or psychiatric public and private hospitals) from state government departments because the collection modes are so disparate. For example, in Queensland:

> *Up to June 1995, [eating disorder] data were reported as separations and from July 1995, as episodes of care.*
>
> *Up to June 1996, coverage of the Qld hospital admitted patient data collection (QHAPDC) was public and private hospitals. From July 1996, coverage was extended to include public psychiatric hospitals* (Health Information Centre, Qld Health, 1998).

Further, the Queensland data base (Health Information Centre, 1998), like others around the country, reports episodes where Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Unspecified (coded according to ICD-9-CM) are recorded as the principal diagnosis. Consequently, patients admitted to hospitals with 'secondary diagnoses', such as depression or gastro-intestinal disorders (as a result of an eating disorder), may not be included in the data base. However, a recent report (Powell and Fleming, 1999, p. 39) cites Qld Health data which indicates that the number of 'bed days' where an eating disorder is recorded as an 'other' condition, that is, not the principal diagnosis for admission, has increased from nearly 4,500 'bed days' in 1993/94, to an average of approximately 10,000 'bed days' for the years 1995/96 to 1997/98.

Attempting to identify trends related to individuals hospitalised for eating disorders remains problematic, in part because the methodology used to obtain these data seems to vary (Health Information Centre, 1998, 2000). Overall, however, revised data from the Health Information Centre, Qld Health (2000) indicate that:

> *...age standardised rates of females hospitalised per year per 100,000 population by age group [for the conditions of –*

Anorexia Nervosa:	*ICD-9-CM 3071*
Bulimia:	*ICD-9-CD 30751*
Eating Disorders Unspecified:	*ICD-9-CM 30750, 30752-54, 30759]*

> *appear to have remained stable over time (1993/94 to 1998/99) when confidence intervals are considered...the rates for anorexia are highest for females aged 15 to 19 years, and lowest for those aged 25 years and over.*

While the number of occupied bed days for eating disorders is significant and primarily a result of anorexia nervosa, in Queensland at least, there appears to be limited variation in the number of occupied bed days from 1993/94 to 1998/99: About 7,700 in 1993/94 which increased to approximately 9,500 in 1994/95 and subsequent years to 1998/99 (Health Information Centre, 2000; Powell and Fleming, 1999).

Of limited comparative value (for example, with Queensland), but nevertheless, useful for successive data collections, is recently compiled information from New South Wales. For example, *in the financial year, 1993/94, there were 623 hospitalisations for anorexia nervosa and bulimia among young people* (90 hospitalisations for those aged between 10-14; 197 between 15-19 and 336 between 20-24 years). *Of hospitalisations for anorexia nervosa, 95.6% were among females and for bulimia, 98.9% were among females.* Anorexia nervosa and bulimia nervosa were diagnosed in 63% of all in-patient episodes within DRG 846 (Eating and Obsessive Compulsive Eating Disorders) and *there were about 313 episodes of in-patient care for anorexia nervosa in 1993/94* (Public Health Division, 1996).

Of particular interest, is data reported by the Hospital Contribution Fund (HCF) that since the previous year *...there has been an almost threefold increase in the number of admissions for anorexia nervosa, although the absolute numbers are still small* (HCF, 1996). The HCF annual report indicated that the average length of stay for anorexia was 36.5 days and the next longest stay was 21.5 days for septic arthritis. The average charge was highest for anorexia ($12,934), more than double for the next highest, post natal depression, ($6,288). Further indications of the high treatment costs for anorexia have been provided by the Medical Benefits Fund (MBF) in NSW. In 1996, anorexia accounted for six of the top 50 benefit payments with costs ranging from $61,196 (ranked 44th) to $84,278 (ranked 6th).

These high costs of treatment constitute a significant health funding issue. With the increasing numbers of admissions and bed days evidenced in both public and private systems, in purely economic terms, prevention becomes an urgent matter.

Attitudes towards eating disordered clients

Clients with eating disorders are among the least liked groups in the health system (Fleming & Szmukler, 1992; DeLaune, 1991). The report of the National Community Advisory Group on Mental Health expressed concern about the attitudes of health professionals, particularly those in the field of mental health, who were identified as the most important source of discriminatory practice (Plant & Hardy, 1994). Similarly, the report, Human Rights and Mental Illness (Human Rights and Equal Opportunity Commission, 1993) identified a range of concerns about the attitudes and behaviours of mental health professionals including nurses. Individuals with psychiatric disorder are usually very sensitive to prejudice and stigma and are particularly vulnerable to the attitudes and behaviour of mental health professionals involved in their care (Malla & Shaw, 1987). Negative attitudes or stereotypes held by health professionals have a detrimental impact on the development of the therapeutic/working alliance (Bairan & Farnsworth, 1989), a significant factor in determining the effectiveness of psychotherapeutic interventions (Horvath & Symonds, 1991; Gallop, Kennedy & Stern, 1994).

Fleming and Szmukler (1992), in a study of 352 medical and nursing staff in a general hospital, found that:

> *Patients with eating disorders were not very well liked by the health professionals studied, even less so than patients with schizophrenia. Furthermore they were seen as having a degree of responsibility for causing their illness, comparable to that of patients who take recurrent overdoses...the more "physical" the illness and the less "psychologically" based, the more sympathetic the attitude* (p. 442).

In an American survey of health professionals, low levels of perceived knowledge and competency in working with eating disorders were reported by physicians, nurses, psychologists, social workers and nutritionists. Overall, respondents were largely uninterested in continuing education to expand their clinical competence (Blum et al. 1990). The attitudes of health professional students towards disabled and mentally ill patients are also a cause for concern (Bairan & Farnsworth, 1989; Lyons & Ziviani, 1995; Malla & Shaw, 1987; Drolen, 1993; Lyons & Hayes, 1993).

Although research into attitudes toward patients with eating disorders is limited, the growing body of literature on attitudes towards mental illness provides considerable insight. Significant attitudinal differences have been found between psychiatric nurses and nursing assistants. In one study, staff with higher levels of training and status were found to be less authoritarian and impersonal, as were male nurses and staff aged under thirty. Nursing assistants had the most authoritarian attitudes (Scott & Philip, 1985). In a Brisbane study of the needs of eating disorder sufferers and their families, participants reported concern about the lack of knowledge of health professionals about eating disorders and their perception that many health professionals viewed these disorders as self inflicted. Participants believed that this attitude influenced the professionals' practice and interaction with them (McFillan, 1998).

One study has found that social relations on hospital wards were strongly influenced by ward culture including the frequent labelling of patients as good or bad (Johnson & Webb, 1995). Such practices give staff the power to define reality and have considerable potential to affect the intensity and quality of care provided to patients. Negative counter transference responses are frequently aroused in nursing staff by patients who exhibit self destructive behaviours such as self-inflicted injury, eating disorders and drug abuse. Feelings of inadequacy, anxiety, anger and retaliation are elicited by these patients whose behaviours are considered to be manipulative and attention seeking (Sebree & Popkess-Vawter, 1991). Patients perceived psychiatric nurses' behaviours to be stereotyping, custodial, rule enforcing, lacking in intimacy and friendliness, lacking in empathy and caring, hostile and condescending (Muller & Poggenpoel, 1996). Sines (1994) challenged practitioners to acknowledge the influence that power relationships have on therapeutic practice and patient outcomes and noted that sanctions such as threats of seclusion or denial of privileges continue to be implemented by some mental health professionals.

The therapeutic alliance

The importance of the therapeutic or working alliance, is well documented. There are various definitions of this alliance, however, common concepts include collaboration, mutuality, and engagement (Gallop, Kennedy & Stern, 1994). A relationship based on equality, trust, mutual respect and involving genuine communication and empathy is essential to a healing process which aims to promote, restore and maintain physical, emotional and spiritual health (Muller, 1996; Sines, 1994; Barker, 1996). The single most important therapeutic skill valued by patients who had been hospitalised involuntarily and were feeling alienated (Younger, 1995), was 'caring listening' which meant nurses' awareness of and sensitivity to the needs and feelings of patients (Joseph-Kinzelman, Taynor, Rubin, Ossa & Risner, 1994). A critical factor in a patient's maintenance of therapy and level of co-operation is their perception of this alliance. Patients' subjective assessment of their experiences of treatment is therefore a valid and essential source of evaluation for staff. Self awareness on the part of the mental health professional is of fundamental importance (Barker, 1996; Landeen, Byrne & Brown, 1992). Factors which have been found to influence attitude change include information and education, persuasive messages (McGuire, 1968; Petty & Cacioppo, 1981), peer pressure (Brauer et al. 1995), induced compliance (Leippe & Eisenstadt, 1994), experiential group learning processes (Desforges, Lord, Ramsey & Mason, 1991) and visual media (Medvene & Bridge, 1990).

A small number of studies have investigated the impact of the working alliance on individual clients and health professionals. The Working Alliance Inventory (WAI) developed by Horvath in the early 1980s was used to demonstrate beneficial impacts for the client of a positive working alliance (Raue, Goldfried & Barkham, 1997). Another dimension of the working alliance was explored through demonstrating that clinicians are inspired by some patients but not by others, and that this perception of a patient as inspiring was associated with a positive working alliance (Kahn & Harkavy-Friedman, 1997). Further, this study identified that inspiring patient qualities included courage, persistence, and an ability to overcome or cope with illness, adversity or trauma. Based on Peplau's work on the therapeutic nurse-client relationship, Forchuk (1995) also used the WAI to study the *uniqueness of each individual nurse-client relationship* (p. 34). She found that individual nurses held different preconceptions about clients, and developed a different relationship with each one in respect to bond, goals and tasks. These findings have important implications for the promotion of a positive working alliance between nurses and eating disordered clients who may present special challenges.

A critical factor in patients' maintenance of therapy and level of co-operation is their perception of this alliance (Gallop, Kennedy & Stern, 1994). Bemis-Vitousek (1998), from the University of Hawaii and keynote speaker at the *Challenge the Body Culture* Conference, provided principles for working with people suffering these treatment resistant conditions (see Chapter 11). She emphasised the need to sensitise health professionals to working with the particular needs of eating disorder clients, and ways of developing an effective therapeutic style: *a way of "seeing" their clients' difficulties which appears to promote empathy* (p. 12). The approach she outlined is in marked contrast to that used by many professionals, because it focuses on developing a truly collaborative relationship between therapist and client, in which the therapist genuinely attempts to understand the client's experience from their own perspective, and assists the client to work on their own solutions. Since so many current treatment approaches appear to have limited success, the implementation of other approaches is essential. As well, investment in training is vital if professionals are to become familiar with and skilled in their use.

Health promotion, education and prevention

These three dimensions are inextricably linked. Because of evidence of the impact of eating issues on children, education to prevent the development of eating disorders and to promote healthy approaches to self-esteem and achievement, eating, appearance, activity and general health must begin at kindergarten stage and continue through the years of primary and secondary education. This is an area where well planned long term collaboration between education and health authorities and providers throughout the country could result in an effective approach to the issue.

In New South Wales, a Ministerial Advisory Committee on Body Image and Disordered Eating was established in April, 1997 (Tranter, 1998). It arose out of a 1996 summit on body image and eating disorders, which focused on *...the impact of the media, fashion and other social pressures on women's body image, and the relationships between that and eating disorders* (p. 257). The Committee focused on strategies to build positive body image and self esteem, and worked closely with the Department of Education and Training to create innovative approaches that dealt with the surrounding issues. The Committee included representatives from a range of government departments including health, sport and recreation, and non-government groups such as advertising, fashion and media industries.

Whilst the results of school based education/prevention programs focusing on an information giving approach have generally been disappointing (see for example, Paxton, 1993; Killen, Barr Taylor, Hammer, Litt, Wilson, Rich, Hayward, Simmonds, Kraemer & Varady, 1993; Neumark-Sztainer et al. 1995), O'Dea (1998) reports positive outcomes from a program based upon building self esteem and thereby improving body image, body satisfaction, and the eating attitudes and behaviours of adolescents:

> *The Everybody's Different intervention was successful at improving the body satisfaction, physical appearance ratings and weight control behaviours of young adolescent participants. The fact that the female students who participated in the intervention gained weight in line with normal female adolescent growth whilst the female control students tended to lose weight suggests that the intervention may have prevented weight loss or weight control behaviours in the female participants* (p. 240).

Paxton (1998) has drawn attention to the role of peer and friendship groups in the prevention or development of disordered eating behaviours. Instances from schools support this finding. An example from a Queensland provincial high school reported by educators, involved a group of friends who took on a bet to see who could lose the most weight during the year. The winner was declared and the girls involved left for summer holidays. When school resumed the following year, the winner of the contest had an established eating disorder (L. Ireland, personal communication, July 1997). Such influences, as well as those of the media in all its guises, the fashion industry, and families, must be taken into account in any prevention program. For an extensive discussion of prevention see Chapter 4.

Community education

The negative influence on young people of stereotyped images, particularly images of female beauty, which are pervasive throughout society and constantly communicated through the media, has been demonstrated in the literature (Stice, Schupak-Neuberg, Shaw & Stein, 1994; Murray, Touyz & Beumont, 1996; Paxton, Schutz, Wertheim & Muir, 1996; Gwynne, 1997). A content analysis of a total of 36 issues of the six most popular Australian women's magazines (BIBH Program Committee of Management, 1996) involved over 200 articles which included content related to body image. Almost half the articles were found to encourage readers to aspire to attain the ideal image presented. There was also found to be marked variation between publications:

> *Girlfriend had the greatest proportion of selected articles that encouraged the reader to aspire to a particular ideal of body size, weight, shape or appearance (68% of selected articles that mentioned an ideal) compared with Cleo for which only 26% of the selected articles that mentioned an ideal actually encouraged aspiration to that ideal* (p. 17).

A further study by this group analysed the Body Mass Index (BMI), that is, height to weight ratio, of Australian fashion models. Data was collected from two modeling agencies, 30 female and 10 male models, selected on the basis of popular agency demand:

> *Female models ranged in age from 16 to 32, with a mean of 23.3. They ranged in height from 1.65 to 1.78 metres with a mean of 1.74 metres, and ranged in weight from 48 to 70 kilograms with a mean of 55.2. All but one reported a dress size of eight or ten. Calculations of BMI scores showed a range from 16.1 to 22.1, with an average of 18.3 (which is well below the healthy weight range of BMI 20-25). These figures show a bias towards thinness, with over 90% of female models included in the study being measured as under the healthy weight range* (p. 18).

Research by Waller and colleagues (Waller, Hamilton & Shaw, 1992; Hamilton & Waller, 1993), demonstrated that exposure to photographs of fashion magazine models, led anorexia and bulimia sufferers to overestimate their body size more than previously. The same effect was found in women, who, although they did not have an eating disorder, held unhealthy and restrictive attitudes towards eating. Later work (Sumner, Waller, Killick & Elstein, 1993) showed that other groups of women who were undergoing body changes such as adolescents and pregnant women also responded in this way to such media images (see

Chapter 6). In his keynote address to the *Challenge the Body Culture* conference, Waller stated:

> *The experimental nature of these studies and their use of real-life fashion images gives strong support to the suggestion that the media play a direct causal role as one of the factors that interact in the development of eating problems. In particular, it seems that one finds these effects most readily among women who already have reasons to focus on the shape of their bodies...Since these studies were conducted, a number of other studies have been carried out, and the results have broadly supported these initial findings. It seems safe to conclude that the media's portrayal of the "ideal" female form as skinny is a pathological influence among those women who already have some of the setting conditions for eating disturbance* (Waller, 1998, p. 26).

This research is of particular concern in light of previously discussed studies which demonstrate clear concern with body size and adoption of the thin ideal amongst younger and younger children.

Attempting to change the images presented in the popular press is a sensitive and difficult area because of the economic basis of the magazines and publishers' perceptions of what sells their product. Waller (1998) concluded that because of the media's agenda which includes generating profit; attracting advertising; gaining a captive audience through convincing readers that the magazine is essential reading on their path to attractiveness; and creating a corporate image which will facilitate all of these; self regulation will never work in any substantial way, and government regulation is the only answer to effecting change in this area. Such regulation would be unacceptable in many quarters. However, in the meantime, increasing numbers of young Australians are paying the price. There are recent examples of editors who have attempted to present more realistic images in their publications paying the ultimate price of losing their jobs for their efforts. The last two editors of New Woman magazine (the first of whom spoke at the 1995 Brisbane forum, and the second at the *Challenge the Body Culture* conference) have both 'left' their editorial roles, seemingly because of concern by advertisers and others that the image the magazine may portray was that of a 'fat woman's' magazine. Some attempts, notably in New South Wales, are being made to establish collaborative processes involving Government, health professionals, and representatives of areas like the media and fashion industry.

In some cases, the marketing of stereotyped images is directed specifically at children, and it could be argued that in this circumstance there is a place for government intervention. Such a case is the Australian *Barbie* magazine released in July 1996, and targeted at girls aged six to twelve years. The content of this magazine raises a number of concerns including the very narrow stereotyped images of beauty and women's/girls roles, and the overwhelming volume of advertising which is blended with information throughout the magazine (Sanders, Gwynne & Gaskill, 1998). Publications targeted at young children is clearly an area in which regulation is justified, unless, as a society, we believe that regarding children as a market niche to be exploited purely for profit, regardless of consequences, is acceptable (see Chapter 7).

Significant counter campaigns are essential to provide a healthy alternative message to young people. Currently there is little evidence that *disease prevention* programs in this area work, but models need to be developed and tested. Some evidence is now emerging for the success of health promotion approaches which focus on the development of positive self esteem and body image through broad social action and education/skills development programs. For example, the Everybody's Different Program in New South Wales, provides *the first randomised, controlled study to demonstrate that the body satisfaction, body image and eating disorders behaviours and attitudes of young male and female adolescents can be significantly improved by general self esteem education* (O'Dea, 1998, p. 241). Similarly, Fleming and O'Hara (1998) argue for the need for health promotion approaches which are holistic and focus on the development of positive body image rather than disease prevention which has a disease focus. The 1997 Australian Medical Association National Conference also favoured a positive health promotion approach, and recognised the need for: (i) the education of young people about the strategies used in constructing media images to empower them to recognise the myth behind the image; (ii) debunking the myth that all fat is bad; (iii) regulation of the media against the constant and unbalanced presentation of the thin image; and (iv) authorities to take responsibility for the problem which is being created in our midst (Cross, 1998). In addition, some of the destructive myths about body size, dieting and health need to be exposed. Such a campaign should present a balanced view of health, with a focus on participation, quality of life, and an acceptance of diversity in body shape and size. The community needs to be made aware of the dangers of dieting and that research has demonstrated that diets do not work. The dangers of obesity are commonly publicised, but the dangers of underweight and of extreme weight loss behaviours are hardly if ever talked about. Healthy eating, positive self esteem, physical activity, and a balanced approach, rather than an obsession with size should be emphasised.

Substantial funding is required to enable a carefully developed long-term national program which is creative and appealing to young people. It should utilise a range of media such as TV, popular magazines, billboards, videos, cinema advertising, Internet and newspapers, and should be strategic in reaching the target audience.

Community based health promotion/education programs are a viable strategy in raising public awareness. An apparently successful model has been developed under the *Body Image and Better Health Program* in Victoria. Similarly, the *Sunshine Coast Body Image and Eating Behaviours Project* (Fleming & O'Hara, 1998), based on the Victorian initiative, has received *High levels of participant satisfaction and professional and community involvement in project activities...*(Fleming & O'Hara, 1998, p. 250). This project initially received a one-off, state government grant and has subsequently received only limited financial support through local health services.

Early intervention

Currently, appropriate and effective early intervention for people developing eating behaviour problems may be difficult to obtain for a number of reasons. Sufferers are often slow to recognise or admit that they have a problem, and therefore to seek help. People with eating disorders are also extremely sensitive to negative comments about their weight loss or their eating behaviours. This type of response from peers, teachers, health professionals or family members may only serve to exacerbate the problem causing the person to withdraw and deny the issue even further. There are numerous reports from teachers, families, and health professionals that many do not know what to do when confronted with someone who may be exhibiting behaviours or symptoms associated with the development of an eating disorder (Sanders et al. 1995; Gaskill et al. 1995). Education strategies for personnel likely to be in contact with people experiencing eating behaviour problems is vital and could improve the process of early response and facilitation into appropriate assistance.

It is purported that early detection and treatment is likely to prevent the development of chronic disability (Touyz, Kopec-Schrader & Beumont, 1993; Crisp, Joughin, Halek & Bowyer, 1996). It is therefore vital that appropriate early intervention is available both in schools and in the community to identify at-risk individuals and channel them into support/treatment services.

A parallel may be drawn with the National Youth Suicide Prevention Strategy, which includes activities related to crisis intervention and primary care. Improved funding for telephone help and counselling lines, general practitioner education, appropriate follow-up and the trialling and evaluation of new service models are addressed. Such strategies, along with others, could be useful in relation to eating disorders.

Research

Despite a burgeoning literature in the area, there are many aspects of eating disorders and other issues in relation to disordered eating that require investigation. Many of these have been identified in the foregoing discussion and in the various chapters of this book. Avenues for funding a variety of both quantitative and qualitative studies to enable continued development of understanding, skills and services in this area need to be identified. Obtaining funding for research which addresses questions of a more holistic or experiential nature is often difficult, in part because the relatively small number of people with an eating disorder preclude methodologies that adhere to strict empirico analytic assumptions. Nevertheless, such research is necessary to build on positive work that is already occurring in many parts of the country, and to draw together the efforts of researchers, educators, practitioners and service providers.

Classifying eating disorders as a mental illness, has, historically, limited the scope of research and type of services offered. Until relatively recently, the bulk of the research literature on eating disorders has arisen from the perspectives of medicine/psychiatry and traditional psychology. However, eating disorders clearly involve psychological, physical, family, individual and social dimensions, and a truly holistic approach is necessary if the issue is to be addressed successfully. The literature tends to focus on epidemiological studies, the etiology and treatment of eating disorders (diagnosed according to DSM IVR criteria), and psychological issues such as demonstrating the links with low self esteem and poor body image, and the incidence of these factors, particularly amongst adolescents. A far smaller body of literature focuses on social factors of various sorts, at individual, family, peer and community levels. The perspectives of consumers (sufferers and families) have been largely neglected, and the large numbers of the population who do not suffer diagnosable eating disorders, but whose lives are disrupted over long periods of time by poor body image and the excessive use of weight control measures, are virtually unresearched. Cross-cultural perspectives on eating issues within multicultural Australia are also under researched.

Another area which requires urgent attention is the development, trialling and evaluation of evidence based practice models at all levels of intervention: education, prevention, early intervention, acute treatment, follow up/ aftercare, and in the realm of social action.

A primary health care approach to intervention

In the National Mental Health Promotion and Prevention National Action Plan, 1998-2003 (Commonwealth Department of Health and Aged Care, 1998) strategies for the prevention of eating disorders are discussed in relation to children 5 to 11 years, young people 12 to 17 years, and young adults 18 to 25 years. Targets include reducing risk factors, improving self worth including healthy body image, and reducing the incidence and prevalence of eating disorders. In addition, research questions relating to identifying strategies effective in preventing eating disorders and in enhancing resilience against developing these disorders are posed. The document identifies a wide range of community settings, organisations and groups, within which these strategies are relevant to, and broadly based on, the principles of the Mrazek and Haggerty Mental Health Intervention Spectrum for Mental Disorders (Mrazek & Haggerty, 1994). This particular model has been adopted in the Mental Health Promotion and Prevention National

Action Plan (Commonwealth Dept. of Health & Aged Care, 1998), produced under the National Mental Health Strategy as the basis for health promotion and illness prevention strategies. The Mental Health Intervention Spectrum identifies three categories of prevention intervention referred to as universal, selective and indicated.

Universal prevention encompasses those interventions directed at the whole population or group, on the basis that they could be of benefit to all, carry no or low risk, and are acceptable to the community. Overall costs need to be considered because of the potential scale of interventions.

Selective prevention describes interventions directed at individuals or groups who are at significantly higher than average risk of developing a particular disorder or health problem. Costs should be moderate and negative impacts absent or low.

Indicated prevention is applied to interventions with individuals at high risk of developing a mental disorder (biological predisposition or early signs of pre-illness problems) or those with early symptoms that are too mild to lead to diagnosis with a mental disorder. The authors state that in this category, it is acceptable for costs to be high and for some risks to be associated with intervention.

Mrazek and Haggerty drew on Gordon's (1983; 1987) classification system for physical disease prevention. They point out that there is considerable confusion related to the classification of various levels of illness prevention, including in the area of mental health. The model specifically targets 'prevention research' to focus on the prevention of mental illness rather than the promotion of mental health. They identify this focus on illness rather than health as the factor which distinguishes the aims of the Mental Health Intervention Spectrum from the broad field of health promotion in the area of mental health. The model also excludes issues of treatment of diagnosed disorders, although the authors acknowledge that there is often considerable overlap between treatment and prevention strategies. These parameters present a significant limitation to utilising the Mental Health Intervention Spectrum as a single organising model in relation to eating issues, including eating disorders. Within this area there is as much if not more need to address broad health promotion strategies, and to improve approaches to the treatment of eating disorder sufferers, as there is to address the prevention of illness as defined by the Mental Health Intervention Spectrum.

The other areas of the model encompassed within treatment and maintenance are more straightforward and self-explanatory. All areas of the model are relevant but not sufficient as a guide in the prevention and treatment of eating disorders and the ongoing support of diagnosed sufferers. Broad health promotion approaches, and vital initiatives required to facilitate programs, including staff education, policy development, legislation, networking strategies, the development of practice standards, evaluation and research, extend beyond this model.

Successful health promotion interventions cannot be conceptualised separately from the social, cultural, family and community settings and influences which surround target populations as they live their lives. There is a need to tackle the structural issues which contribute in powerful ways to the social milleau within which body image, self esteem, and disordered eating behaviours are creating increasing concern.

A broader approach to health promotion in this area is offered by the model of Primary Health Care as embodied in the Ottawa Charter for Health Promotion (WHO, 1986). This model is holistic, based on a social model of health, and while it focuses on health promotion and disease prevention, also encompasses medical and treatment issues. It can be used as the basis of interventions at population, family and individual levels. The Charter involves five action areas:

- Build healthy public policy

  This action area aims to create a recognition that all areas of public policy within any society have intended or unintended health impacts, and in the interests of public health, the health implications of all policy should be considered prior to implementation. The safety of goods and services in the broadest terms, issues of equity, and the provision of adequate funding need to be considered, and obstacles to healthy policy identified and addressed.

- Create supportive environments

  This action area is of particular relevance to the current climate, within which body image, self esteem and disordered eating issues exist. It encompasses physical, work, social and community environments. Health is inextricably bound with other issues in our physical and social environments and promoting the health of the public should include developing environments within which people are supported to be healthy, rather than is so often the case, having to battle against a range of illness creating influences. Media, fashion, diet and other industries which contribute to the current unhealthy thin body ideal, often argue that they are not to blame because not all young women exposed to their messages develop eating disorders. In their resistance to any regulation in the interests of public health, which may limit their activities, these commercial interests blame 'weak' individuals for their problems, and continue to promote a social climate in which dissatisfaction with the body, particularly for women, is the norm rather than the exception. Responses to counteract such influences are always at individual and taxpayer expense, whilst the profits from the activities concerned generate enormous private profit. Application of this action area would require such issues to be addressed at policy and structural levels. A further emerging challenge is presented by cyber culture which is now developing new and disturbing trends in the commodification of womens' bodies (Hawthorne & Klein, 2000).

- Strengthen community action

  Empowerment of the community is a central issue, and community development a major strategy in achieving this action area. In planning and implementing health promotion programs, the priorities and concerns of the community must be sought, incorporated and addressed. The community itself, not only professionals and bureaucrats must be part of decision making and priority setting processes.

- Develop personal skills

  Within this action area are included all the strategies for increasing individuals' options for improving and maintaining health and gaining control over their own health. Programs aimed at providing information and increasing skills in all their guises are included here. Generally the universal, selected and indicated interventions from the Mrazek and Haggerty (1994) model would fall under this action area.

- Reorient health services

  If complex health issues are to be adequately addressed, health services must be reoriented to a broader focus based on a social model of health, which implements the principles of primary health care in the promotion of health and the treatment of disease. Provision of funding for health promotion, promotion of community participation and intersectoral collaboration, support of a much broader research focus, and an holistic approach including individual, family and population foci, are included.

These five areas are based on a foundation of advocating, enabling and mediating for health. The more recent Jakarta Declaration (WHO, 1997) reaffirms this approach set down in the Ottawa Charter. It states that *there is now clear evidence that comprehensive approaches to health development are the most effective. Those which use combinations of the five strategies are more effective than single track approaches* (p. 3). In addition, the Declaration encourages collaboration between governments and private enterprise in promoting the health of populations.

In a public health sense, the issues which need to be addressed if we are to respond effectively to the area of eating disorders and disordered eating behaviours, are necessarily broad. Whilst there is a relatively small number of chronically ill anorexia and bulimia sufferers in relation to the number of people experiencing more general disordered eating behaviours these individuals are costly to treat and utilise a high number of hospital bed days. On the other hand, the costs in terms of lost productivity, health complications, mental, emotional and social health of both diagnosable eating disorders and disordered eating behaviours, is unmeasured and largely unmeasurable. It is not only eating disorders which constitute a public health issue, but the range of manifestations on the continuum of disordered eating behaviours.

To a large extent the focus in policy and intervention to date has been on improving the skills of individuals to be more resilient, or to develop improved self-image in order to prevent illness. This is only part of the picture. The broad health promotion, health policy and health education/support strategies necessary for dealing with and preventing eating disorders will require the difficult structural issues to be effectively addressed. The approach presented in the Ottawa Charter and Jakarta Declaration could provide a model for effective action in the future: A model that addresses not only individual change, but also structural change.

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Part II: Social Factors and the Body Culture

So what should be done? First, we need more evidence about whether it is possible for prevention programs to reduce the pathological influence of the media's portrayal of women. Second, it would be valuable if the media were to use a broader range of models, so that no one body shape is presented as ideal, but all shapes are seen as acceptable. Will the media accept such a change as part of a voluntary code of practice? 'No' seems to be the only sane answer to that question. The alternative would seem to be the route of imposing legislation to prohibit the use of such pathological images. Surely, it would take a mad person to call for such a course of action. However, I think that the situation is mad enough to require that I suggest that we should be going down just that road (Waller, Chapter 6).

Chapter 3 – Individual Risk Factors and Socio-Cultural Contexts for Disordered Eating

Susan J. Paxton

Over the last 30 years there has been a dramatic increase in the prevalence of eating disorders in the western world and in Australia the prevalence is 2-3% of adolescent and adult females (Ben-Tovim, Subbiah, Scheutz & Morton, 1989; Clayer, McFarlane, Bookless & Air, et al. 1995; Hay, Marley & Lemar, 1998). While the prevalence of anorexia nervosa has most likely increased only modestly due to an increase in younger presentations (Szmukler & Patton, 1995), bulimia nervosa and binge eating disorders were virtually unknown until recently and account for the majority of the rise (Szmukler & Patton, 1995). These eating disorders have increasingly been viewed as falling on a spectrum of severity from positive body image and healthy eating behaviour to extreme body disparagement, use of extreme weight loss behaviours and clinical disorder(e.g., Patton, 1988; Shisslak, Crago & Estes, 1995; Striegel-Moore, Silberstein, & Rodin, 1986). Shisslak et al. estimate the prevalence of partial syndrome eating disorders in non-clinical populations to be twice that of full syndrome disorders. There is strong empirical support for the view that there is frequently within an individual a progression from less severe to severe eating disorders (Franko & Omori, 1999; Hsu, 1990; Shisslak et al. 1995). It is, therefore, important that risk factors for less severe and body image and eating problems be understood.

Only changes in environmental factors are likely to account for the dramatic epidemiological change over such a short time. Cultural attitudes regarding women and the female body are clearly the strongest contenders as risk environments. These are articulated most clearly in socio-cultural and feminist analyses of the relationship between culture and eating disorder described further below. Yet there is marked variation in body image satisfaction and use of weight loss strategies within our society. Why are some individuals more vulnerable than others? The present chapter aims to examine briefly the nature of risk environments and subcultures and individual factors which potentially contribute to vulnerability to eating disorders. Understanding risk and protective characteristics, experiences, and environments can help elucidate causal mechanisms, as yet poorly understood, though it does not give clear direction as to the mechanisms translating risk into frank eating disorders. In addition, understanding individual characteristics, which frequently precede the development of eating disorders, may indicate potentially effective methods of prevention or early intervention at an individual level. Further, an appreciation of risk environments and their interaction with vulnerable individuals, highlights the need for social action and the need for change at cultural and sub-cultural levels.

A risk factor is a characteristic, experience or event which has been shown to precede a deleterious outcome and which is associated with an increased likelihood of that outcome, while a protective factor is one that decreases the likelihood of an undesirable outcome or increases the likelihood of a positive outcome (Kazdin, Kraemer, Kessler, Kupfer & Offord, 1997). These factors may be environmental or individual in origin. Longitudinal or experimental research is usually required to confirm that a risk factor precedes the development of a disorder. If a causal link between a factor and disorder can be demonstrated it may be described as a causal risk factor. Some variables (fixed markers) increase the likelihood of occurrence of a disorder but are not changeable, such as being female in the case of eating disorders. While valuable in providing the context, identification of potentially changeable risk factors is of primary importance to those interested in prevention.

A factor concurrently associated with a disorder is described as a correlate (Kazdin et al. 1997). Correlates are easier to identify as they can be ascertained in cross-sectional research. In the area of eating disorder research, in which very large samples need to be followed up in order to obtain a sizable sample of new eating disorder cases, and the ideal time points of assessment in order to detect risk factors are not known, some factors currently regarded as correlates may prove later to be causal risk factors for the disorder, though they may not. Correlates may also interact to maintain or exacerbate poor body image or disordered eating once initiated. For these reasons, correlates must not be assumed to be causal but are still important to consider when exploring vulnerability in such a complex area as disordered eating.

Cultural and subcultural attitudes such as the current thin beauty ideal in the western world, and its propagation through all channels of mass media, may be considered in the latter category. It is difficult, for example, to conduct a controlled study manipulating increase in intensity of cultural support for the thin beauty ideal in order to determine the extent to which it can technically be described as a risk factor but it would be foolish to ignore this as a possibility in light of evidence of associations between higher rates of disordered eating and environments in which dieting and slimness appear to be highly valued. Bearing in mind causal risk factor status can only be substantiated in a few areas in eating disorder research at present, subcultural environments which may increase the risk of unhealthy dieting and disordered eating will first be examined before reviewing individual risk factors.

Being female

The strongest risk for body dissatisfaction and disordered eating is being female. All comparisons of the prevalence of body image and eating problems between males and females, at sub-clinical and clinical levels, indicate that while there are some males who do have these difficulties, it is relatively unusual (e.g., Paxton, Wertheim, Gibbons, Szmukler et al.1991; Rastam, Gillberg & Garton, 1989). Sex specific physiological risks have been proposed such as hormonal factors especially following puberty, but supporting evidence is scant and they do not offer an explanation for the recent increase in disordered eating. Evolutionary approaches to understanding disordered eating combine genetic predisposition with present social conditions. Such approaches assume that there is evolutionary preference in males to select a fertile mate, but one who has not previously had children. Thus, males are sensitive to visual cues indicative of youth and good health (Ridley, 1993), in particular, a slim figure with a low waist-to-hip ratio (Singh, 1994). As women compete with other women for eligible males on these appearance grounds, Abed (1998) proposes females are genetically predisposed towards being appearance conscious. Further, he argues that in western societies in which women are marrying and having children later, there is pressure to preserve this nubile figure beyond the age of genuine nubility and to attempt to counteract the usual physiological tendency towards weight gain and increased waist size through self-starvation, which then may precipitate disordered eating. While this theory is a better explanation of disordered eating in adult women than early adolescents and difficult to substantiate, the notion that females compared to males are at risk of dieting disorders due to a greater evolutionary concern with appearance is tenable. However, from a public health perspective such a theory is not very helpful as it does not suggest a potential point of intervention.

Socio-cultural and feminist models attempt to understand why females are particularly vulnerable to eating disorder by examining risk cultural environments. Feminist theories of eating disorders are diverse but they all hold that cultural constructions of gender are central to the aetiology of these problems (Striegel-Moore, 1995; Thompson, Heinberg, Altabe, Tantleff-Dunn, 1999; Wooley, 1995). Typically they propose two inter-related cultural factors associated with increased risk of eating disorders: (1) cultural disempowerment of women; and (2) the pressure to attain an unrealistically thin, culturally imposed beauty ideal.

Sesan and Katzman (1998) conceptualize eating disorders as disorders of power suggesting *a retreat to eating-disorder pathology may be the only response that makes sense to a woman challenged by our culture's sexism* (p.82). Katzman and colleagues note however, that self-starvation is observed in females in other cultures and propose that food refusal may be a globally employed strategy to attempt to free oneself from another's control (Katzman & Lee, 1997). The preponderance of females with disordered eating *may not simply reflect the internalization of popular media messages but rather a fairly universal difference for males and females in the task of establishing self-definition and self-control* (Katzman & Lee, 1997, p.389). These theories gain support from observations that anorexic patients frequently cite control over their body as an important motivating influence (Sesan & Katzman, 1998) but, while providing an explanation as to why females are more at risk of self-starvation disorders than males, this approach does not provide a strong explanation for the rise in prevalence of bulimia nervosa especially in the western world. The present thin beauty ideal for women provides a stronger explanation.

Issues of physical and sexual abuse are closely related to power. While it is unclear the extent to which such abuse is a specific risk factor for eating disorder, as opposed to other psychological problems, there is considerable retrospective data to indicate that childhood abuse is over-represented in eating disorder patients compared with normal samples (e.g., Brown, Russell, & Thornton, 1999; Brown, Russell, Thornton & Dunn, 1997; Kenardy & Ball, 1998; Wonderlich, et al. 1996; Wooley, 1995; Zlotnick, Hohstein, Shea, Pearlstein, et al. 1996). In the presence of certain socio-cultural environmental factors, such as the value of a woman being measured or elevated by conformity to the prevailing thin beauty ideal, physical and sexual abuse may increase the risk of disordered eating.

A number of excellent reviews of research literature confirm that the beauty ideal for women has become increasingly thin since the 1960s despite the average size of women increasing (e.g., Stice, 1994; Thompson et al. 1999), and examination of the main propagators of female fashion and image, fashion magazines and television, highlight this trend (Levine & Smolak, 1996; Levine & Smolak, 1998). While a causal relationship cannot be assumed on the basis of current research, the rise in bulimia nervosa has taken place since this time, and it is highly likely this fashion has created a risk environment for disordered eating. In females especially, being thin has gained meanings in addition to beauty. It is associated with control, success and achievement while, in contrast, being overweight is associated with being out of control, laziness, greed and failure. Striegel-Moore (1995) proposes (consistent with evolutionary approaches) that *women's relational orientation renders them vulnerable to others' opinions and behaviors, particularly during adolescence* (p.227).

While fashion endorses the emaciated female body, this shape is one that for genetic and physiological reasons is impossible to attain on a healthy diet for the vast majority of women and may be seen as tantamount to rejection of natural feminine shapes. This biological reality is concealed and in its place *our culture promotes the view of the human body as infinitely malleable and considers weight a matter of personal choice* (Striegel-Moore, 1995, p.214). Under these social pressures many females resort to attempts to control their weight through dietary restraint or more extreme weight control strategies and find themselves in a combative relationship with their natural physiology. If, as proposed below, dieting itself is a risk factor for eating disorder, cultures which endorse a biologically unnatural, thin beauty ideal in women are likely to provide an environmental risk for the development of disordered eating.

The pressures to be thin show no sign of diminishing in the western world. The reasons why this ideal for women is so strongly sustained are complex. In addition to the beliefs about the virtues of thinness now so prevalent, they include role changes for women in which motherhood, and consequently more maternal shapes, is not highly valued; a fat phobia supported by current health messages; and enormous commercial interests in the weight loss industry with a vested interest in maintaining current obsessions regarding weight. Even in the absence of strong longitudinal or experimental data, our culture which endorses the extremely thin beauty ideal for females must be considered a powerful risk environment.

Risk sub-cultural environments

Despite widespread attitudes favouring slimness in females in the western world and body dissatisfaction being the norm, only a relatively small proportion of individuals use extreme weight loss strategies, binge, purge or self-starve. Sub-cultures may act as filters, intensifying or diminishing the pressures to diet, increasing or decreasing risk for eating disorder. Consideration of risk sub-cultures started in the examination of eating disorder symptoms in ballet schools (e.g., Szmukler, Eiser, Gillies & Hayward, 1985). Research has extended to examination of family, peer and media subcultures which have been proposed as *probable carriers of the sociocultural messages* (Stice, 1994, p.644), though in the case of family in particular, risk or protection may also be conveyed through biological and relational links.

Family risk factors

Aspects of the relationship between family factors and daughter's eating behaviour which have received research attention include (1) genetic factors; (2) family concern about shape and eating; and (3) family functioning characteristics.

Studies of potential genetic links are in very early stages but twin studies, in particular, do support the contention that eating disorders run in families and that part of the reason for this is genetic (Treasure & Holland, 1995). Treasure and Holland suggest that specific genetic factors are more likely for anorexia than bulimia nervosa, while in the case of bulimia nervosa *a more general predisposition with links with substance abuse, affective disorder and obesity is seen* (p.77). Franko and Orosan-Weine (1998) point to the potential importance of maternal obesity suggesting that as body weight and shape are largely genetically determined and girls of overweight mothers are consequently more predisposed towards obesity, girls of obese mothers may find it more difficult to lose weight because of biological factors. Franko and Orosan-Weine suggest that as a result, girls whose mothers are overweight may be at risk for resorting to more extreme measures of weight control such as strenuous dieting or purging. Presumably the same may be true of paternal obesity.

Cross-sectional studies generally support the family environment as being an important mediating sub-culture. Numerous studies have reported positive correlations between parental (usually mother) and daughter body image dissatisfaction or dieting concerns supporting modeling of these attitudes and behaviours (e.g., Attie and Brooks-Gunn, 1989; Benedikt, Wertheim & Love, 1998; Hill & Franklin, 1998; Leung, Schwartzman & Steiger, 1996; Pike & Rodin, 1991; Wertheim, Mee & Paxton, In Press a). Some studies, however, have failed to observe this relationship (e.g., Thelen & Cormier, 1995; Moreno & Thelen, 1993). A recent cross-sectional study of 15 year old girls has addressed potential mechanisms through which parents may have an impact on their daughters' eating behaviours, modeling and reinforcement. Wertheim, Mee & Paxton (In Press a) obtained reports from daughter, mother and father triads. Consistent with other research (e.g., Strong & Huon, 1998; Wertheim, Martin, Prior, Sanson & Smart, In Press), they observed that daughter's dietary restraint was predicted by mother's encouragement to lose weight with and without controlling for daughter's body mass index (BMI), supporting a reinforcement model. Dietary restraint was not predicted by parental restraint. On the other hand, daughter's food abstention behaviour was predicted by both mother and father abstention behaviour and to a lesser extent mother encouragement suggesting that more extreme behaviours may be modeled within the family context.

While usually observed as correlates, parental concerns about weight have not consistently been observed as prospective risk factors for deterioration in eating behaviour in longitudinal research (e.g. Attie and Brooks-Gunn, 1989; Gardner, Friedman & Jackson, 1998; Stice 1998). However, the potentially causal relationship between parental and daughter concerns would not be apparent if the transmission of concern had taken place prior to the first assessment occasion. The possibility of this is supported by a recent prospective study by Stice, Agras and Hammer (1999) of children from birth to 5 years, assessing disturbed eating patterns in children and parental BMI, body image and eating behaviours assessed in the child's first month of life. They found evidence that maternal BMI during infancy predicted emergence of inhibited eating, while maternal disinhibition, hunger, body dissatisfaction, bulimic symptoms and BMI, as well as paternal history of overweight, predicted the development of secretive eating. Maternal restraint and drive for thinness, in addition to infant BMI, predicted the emergence of overeating. While different mechanisms may be proposed, and the relationships between these behaviours and eating disorders are not clear, this intriguing study does suggest maternal body image attitudes and eating behaviours may be risk factors for unusual eating patterns from a very young age.

On the basis of observations in family therapy with patients with eating disorders, research has investigated the relationship between family functioning characteristics and eating disorder. In a review of this literature, Humphrey (1994) concluded that families with a member who showed bulimic problems tended to be more chaotic and hostile, while those with an anorexic member were more likely to be more rigid and dependent. While cause and effect cannot be determined, concurrent research demonstrates that girls who have greater eating disorder symptoms tend to come from families in which there is lower perceived family cohesion and organization (e.g. Attie & Brooks-Gunn, 1989; Hill & Franklin,1998) and greater parental overprotection and lower caring (e.g., Wertheim, Paxton, Maude, Szmukler, et al. 1992). Strong and Huon (1998) observed that in adolescent girls perceived parental encouragement of autonomy and self-confidence were associated with less dieting. In a study employing a structural equation modeling, Leung et al. (1996) found that while family preoccupation with weight had a direct effect on girls' weight preoccupations, general family dysfunction had a direct effect on self-esteem, and indirect effects through negative self-esteem on eating and psychiatric symptoms.

In a retrospective design, Fairburn, Welch, Doll, Davies and O'Connor (1997) compared bulimic and control subjects and psychiatric patients on a range of potential risk factors. They found that while bulimic patients were exposed to a substantially greater number of potential risk factors than control subjects, only four factors differentiated the bulimic and psychiatric controls. These were negative self-evaluation, childhood obesity, parental high expectations and critical comments about weight shape or eating. In addition to highlighting the likelihood that bulimia nervosa is the result of exposure to risk factors for psychiatric morbidity in general plus those that encourage dieting, it is notable that two of the differentiating factors are associated with family attitudes and behaviours.

Longitudinal studies examining whether aspects of family dysfunction precede the development of disordered eating have been few. Swarr and Richards (1996) in a two year follow-up of adolescent girls found that positive relationships with both mother and father prospectively predicted healthier eating scores. Further research is required in this area.

In summary, while there is not conclusive evidence that family sub-cultural factors are causal risk factors for body image dissatisfaction and disordered eating, a range of concurrent and retrospective research strategies do suggest this is most likely.

Peers

The peer sub-culture is widely recognized as a very important developmental context for adolescent girls. Over recent years research examining the relationship between a girl's body image and eating behaviours and her peer environment confirms strong associations. As indicated in the following discussion some peer variables may have a causal role in the development of disordered eating, especially teasing. Others may provide an environment which sustains these concerns though may not be causal.

There is consistent evidence that adolescent girls who have poor body image and disturbed eating patterns compared to those who do not, perceive their friends to be dieting and talking about weight loss techniques more frequently (Gibbs, 1986; Levine, Smolak, Moodey, Schuman & Hessan, 1994; Paxton, Schutz, Wertheim & Muir, 1999) and to be more concerned about thinness and dieting (Paxton et al. 1999). In an examination of factors associated with weight concerns in adolescent girls, Barr Taylor, Sharpe, Shisslak, Bryson et al. (1998) observed that in elementary and middle school girls the perceptions of importance that peers put on weight and eating was the strongest predictor of weight concerns in a cross-sectional survey. These data do not necessarily reflect on the actual, as opposed to perceived, peer sub-culture as it is possible that a weight concerned girl may assume her friends share her values, whether they do or not.

Recent research, however, suggests that these perceptions are likely to be accurate. In a study of year 10 girls, members of friendship cliques were found to be similar on measures of body satisfaction, dietary restraint and use of extreme weight loss behaviours, after friendship group BMI, depression and self-esteem were taken into account (Paxton et al. 1999). Further, there were significant correlations between mean friendship clique scores on these body image and eating variables and the extent to which friends were concerned about and talked about thinness and dieting, suggesting some friendship groups were high weight/shape preoccupied subcultures while others were not. In this study, the extent of a girl's use of extreme weight loss behaviours could be predicted from the mean level of use of extreme weight loss behaviours of her friendship clique. Friendship group similarities have also been observed for bulimic symptoms (Crandall, 1988; Pike, 1995) though this was not observed in the Paxton et al. (1999) study. While these data broadly support friendship group similarities, and subcultures of varying intensity of weight and shape concern, it must be noted that the mechanisms involved in creating group similarity are not understood. Similarity may be due to girls becoming more like their friends, but may equally be due to girls choosing friends with whom they share values and behaviours. In the latter case the subculture is not a causal risk factor, but could normalize body image dissatisfaction and disordered eating and contribute to their perpetuation.

Weight related teasing is a more overt way peers and others (including family) may convey cultural values and directly impact on an individual. There is strong research support suggesting teasing is an important causal risk factor for body dissatisfaction and disturbed eating. Peer teasing is correlated with BMI (Wertheim et al. 1997), but even after BMI has been accounted for it has been concurrently associated with dieting and body dissatisfaction (e.g., Barr Taylor et al. 1998; Paxton et al. 1999; Stormer & Thompson, 1996). Retrospective accounts suggest critical comments about weight are viewed as having an important role in the development of negative body image attitudes (e.g., Cash, 1995; Rieves & Cash, 1996; Garner, 1997).

More importantly, for the identification of potential causal risk factors, weight related teasing has been shown to predict later development of symptoms of disordered eating (e.g., Thompson, Coovert, Richards, Johnson, & Cattarin, 1995; Wertheim, Koerner & Paxton, In Press c). In a three year follow-up study of adolescent girls, Thompson et al. (1995) observed that level of obesity at time 1 significantly influenced teasing at time 1, as well as weight and appearance dissatisfaction at time 2. Further, peer modeling has been observed to prospectively predict the onset of binge eating and purging (Stice, 1998).

While the potential negative impact of peer environments has been raised, positive peer influence has been identified as a potentially important protective factor against weight concerns. In an interview study, one girl reported having stopped vomiting when her friends had dissuaded her (Wertheim et al. 1997). The peer environment appears to provide an important subcultural context for body image and eating behaviours, but to date the only strong peer related contender for a causal risk factor for eating problems is weight related teasing.

Media contexts

The presentation of thin idealized images in media over recent decades has been associated with the increased frequency of disordered eating (Levine & Smolak, 1998 for detailed review) and adolescent girls have reported media and fashion to exert the strongest pressure to be thin (Wertheim et al. 1997). However, this general observation does not account for why some women develop body image and eating problems while others do not. Two explanations are most plausible: that media exposure varies and/or vulnerability to media presentations of idealized women varies.

There is mixed support for the proposition that those more exposed to media are more vulnerable to eating disorder (e.g., Cusumano & Thompson, 1997; Harrison & Cantor, 1997). This implies a somewhat passive position but adolescents probably are active selectors of media and media type. Tiggemann and Pickering (1996) reported that while amount of time viewing general television was not correlated with body dissatisfaction and drive for thinness in girls, girls who watched more soap operas and movies showed greater body dissatisfaction and those who viewed more music videos reported greater drive for thinness. Girls with body image and dieting concerns may be influenced by this style of television to be more weight concerned but they may also prefer to select different media. A study by Stice, Schupak-Neuberg, Shaw and Stein (1994) of college women suggested the effect of media exposure on eating disorder symptoms may be mediated by other factors. In addition to a direct path from media exposure to eating disorder symptoms they also identified a pathway from media exposure to gender role endorsement, to internalization of the thin ideal, to body dissatisfaction and to eating disorder symptoms.

Research with clinical samples suggests those who develop eating disorders may have been especially prone to the influence of media. In a retrospective study, Murray, Touyz and Beumont (1996) found that 60-80% of a sample of eating disordered patients believed they had been influenced by the media to desire to achieve the slim beauty ideal presented. Waller, Hamilton and Shaw (1992) have observed an eating disorder sample to increase their body size estimation following exposure to female fashion images while the control group did not. What may cause this vulnerability?

In a study of 15 year old girls, Durkin and Paxton (1999) have examined predictors of short term body image satisfaction changes following exposure to idealised images of young women presented in women's magazines. They observed that girls who already had poor body image and who were more prone to comparing their body with those of others were at significantly greater risk of a reduced body image satisfaction from pre-exposure to post-exposure. While these findings suggest individual characteristics likely to increase vulnerability to thin media images, at this stage these findings cannot be assumed to relate to long term increases in body dissatisfaction and disordered eating.

Levine, Piran and Stoddard (1999), highlighting the paucity of both theory and research in this area, suggest *there is some evidence that media portrayals of slenderness both reflect and contribute to awareness and internalization of the slender ideal, as well as (and thus to) body dissatisfaction, unhealthy weight management, and disordered eating in girls and women who are vulnerable to these influences* (p.8). In addition, media may also directly endorse use of weight loss strategies through promotion of weight loss products. Further, Levine and Smolak (1998) also suggest that the role of the media is likely to change at different developmental stages. There is clearly much work to be done in order to understand the role of media and mechanisms by which they may have effect.

Cumulative pressures

While subcultural factors potentially effecting the development of disordered eating have been considered separately above, they are likely to interact. Stice and Agras (1998), using a measure of perceived pressure to be thin which incorporated pressure from a range of sources, found perceived sociocultural pressure to be thin prospectively predicted onset of binge eating in female adolescents. It has also been observed that the greater the range of pressures perceived by an individual to be slim and to be engaged in weight loss behaviours (e.g. from parents, peers and media) the greater the likelihood of disordered eating (Levine et al.1994; Dunkley, Wertheim & Paxton, In Press). Again, it is important to note these studies rely on reports of perceptions rather than actual pressures. While a person concerned with weight may be more prone to perceive pressure coming from all sources, it is also possible that if pressure is perceived from more than one source both are regarded as more valid.

Individual risk factors

Individual risk factors for disordered eating are intimately associated with cultural and subcultural demands and it is most likely that they act to make an individual particularly sensitive to cultural pressures. While risk environments must therefore be considered, it is also important to understand characteristics likely to make an individual vulnerable to these social pressures.

Many studies find that the strongest predictors of weight loss concerns, poor body image and dieting behaviours in adolescent girls on a later measurement occasion are weight loss concerns, poor body image and dieting on the first occasion of assessment, indicative of the high stability of these attributes (e.g., Calam & Waller, 1998; Wertheim et al. In Press c). However, taking this stability into account, higher BMI has been observed in longitudinal studies to be a major predictor of weight concerns and symptoms of disordered eating (e.g., Keel Fulkerson & Leon, 1997; Stormer & Thompson,1996; Thompson et al. 1995). The longitudinal study conducted by Stice and Agras (1998) is a notable exception. However, their study was conducted later in adolescence (16-19 years) and the authors suggest that timing may be important. BMI may predict onset of bulimic pathology early in adolescence but not later. While some genetic predispositions have been postulated as described earlier, at present there seems to be no physiological reason why higher BMI per se should be a risk for eating disorder. For an explanation we must look to cultural factors. Clearly, in a fat phobic society those with higher BMI are likely to take more extreme and potentially unhealthy measures to try to fit the mould of modern beauty. While BMI may be considered a risk factor, it is more appropriate to consider the negative social reaction to higher BMI, (such as teasing), and the consequent self-disparagement as the risk factor.

Weight concerns and poor body image on an earlier measurement occasion have frequently been reported to be risk factors for eating disorder symptoms in longitudinal studies independent of BMI (Attie & Brooks-Gunn, 1989; Killen, Barr Taylor, Hayward, Wilson et al.1994; Killen, Barr Taylor, Hayward, Haydell et al.1996; Stice & Agras, 1998; Thompson et al. 1995; Wertheim et al. In Press c). The extent of internalization of the thin beauty ideal is also a predictor of onset of bulimic symptoms (Stice & Agras, 1998; Stormer & Thompson, 1996). This is likely to be due to their relationship with dietary restraint.

Dietary restraint seems to be a key issue in the development of most eating disorders. As with weight concerns, there is considerable stability in dieting behaviour and drive for thinness over time (Calam & Waller, 1998; Leon, Fulkerson, Perry, & Early-Zald, 1995; Wertheim et al. In Press c). However, dietary restraint also appears to be a critical risk factor for the development of eating disorder symptoms. Patton, Selzer, Coffey, Carlin and Wolfe (1999) found, in a three year prospective study of adolescent girls, that extreme dieters were 18 times more likely, while moderate dieters were 5 times more likely, to develop eating disorder symptoms than non dieters. In a 9 month follow-up of older adolescents, Stice and Agras (1998) found dieting to be the strongest predictor of onset of binge eating and compensatory behaviours.

Dieting is typically presented to the public, especially in advertising for the weight loss industry, as a virtuous activity, promoting health and beauty. This is far from the truth. Not only is dietary restraint seldom successful as a weight management strategy but it clearly increases risk of disordered eating. Szmukler and Patton (1995) suggest that while the mechanism linking dieting and disordered eating is not clear, the higher frequency of eating disorders in our time and culture relates to the higher frequency of dieting. As a behaviour that may be changed, dieting seems a critical risk factor to be targeted in prevention strategies.

A number of studies have examined personality factors which may put adolescent girls at particular risk for being sensitive to sociocultural pressures to be thin and consequently to dieting. Poor self-esteem has been proposed as a risk factor but the main study in its support, which found self-esteem assessed at age 11-12 years to predict eating disorder symptoms at age 15-16 years, failed to account for eating symptoms on the first assessment occasion (Button, Sonuga-Barke, Davies & Thompson, 1996). It is, therefore, unclear whether poor self-esteem actually preceded the eating disorder symptoms. Calam and Waller (1998) followed a sample of girls from 12 to 19 years. They observed that low self-esteem in early teenage years showed a tendency to predict bulimic symptoms and control over food intake in early adulthood, but did not reliably predict eating psychopathology. They concluded self-esteem was only weakly linked with subsequent eating. No predictive role for self-esteem was observed by Keel et al. (1997). Thus, at present, it is difficult to ascertain whether self-esteem is a risk factor for or a correlate of disturbed eating. Similarly, ineffectiveness seems only a weak predictor of later development of disordered eating (e.g., Graber, Brooks-Gunn, Paikoff & Warren, 1994; Killen et al. 1996; Leon et al. 1999). Self-confidence has been observed in one study to predict the development of weight concerns (Barr Taylor et al. 1998).

Other measures of temperament have been explored as risk factors. Results have been inconsistent. A number of studies have failed to find that measures of temperament or psychopathology predict symptom development (e.g., Attie & Brooks-Gunn, 1989; Killen et al.1996; Patton, Johnson-Sabine, Wood., Mann & Wakeling, 1990). Leon et al. (1995) failed to find that measures of personality (e.g. negative emotionality, stress reaction) predicted high risk for eating disorders at a two year follow-up of adolescents. But at a 3-4 year follow-up (Leon et al. 1999), negative affect/attitudes at study entrance was a significant predictor of later eating disorder. Closer investigation of the high symptom group indicated high comorbidity, especially with mood, anxiety and substance-use disorders. Stice and Agras (1998) did find in a nine month prospective study that negative affect was a predictor of the development of compensatory behaviours. The discrepancies in these studies may partly be related to the different age groups and follow-up times used. At present there is tentative support for negative affect to be a predictive risk factor but further research is required to clarify the relationship. It may be speculated that girls who are unhappy for many reasons may seek to improve their lives by pursuing the stereotyped image of happiness, success and control for females in our culture – the very thin body.

A number of other individual risk factors for disordered eating have been proposed. There is evidence suggesting early puberty or being out of synchrony with peers in pubertal status may be a risk factor (Keel et al. 1997; Swarr & Richards, 1996) but this effect seems to decrease as girls become older and pubertal stage becomes less variable within the peer group (Leon et al. 1999). Life stress has been proposed as a risk factor, but longitudinal studies suggest a causal role for disordered eating in the development of stress rather than the reverse (Ball, 1999; Rosen, Tracy, Howell, 1990). Finally, body comparison, the extent to which an individual compares her body with those of others, recently has been found to be strongly correlated with dieting, body dissatisfaction and disordered eating symptoms (Stormer & Thompson, 1996; Paxton et al. 1999; Schutz, Paxton & Wertheim, under review). This attribute may make a girl particularly sensitive to any discrepancy, real or perceived, between her body shape and the current beauty ideal and it is currently under investigation as a risk factor for the development of dieting (Schutz et al. under review). Further, longitudinal research is required to clarify individual risk factors for disordered eating and their interaction with social factors.

Conclusion

This review has examined risk environments and risk factors for the development of weight concerns and disordered eating. Our culture, in which females lack power in comparison to males, and which endorses an attitude that female beauty is dependent on a very slim build, appears to put females at risk of disordered eating. Subcultural attitudes and behaviors may confer added risk, especially those in which a high value is placed on thinness and social censure is directed towards those who do not conform to the beauty ideal. For reasons of physiology or temperament, some individuals may be at greater risk than others for disordered eating and this is likely to be exacerbated within a high risk environment. However, any factor which leads to dieting seems to be especially dangerous for the development of disordered eating. It might be speculated that exposure to one risk factor alone is less likely to result in the development of disordered eating. Rather, exposure to a greater range of both individual and environmental risks probably increases the chance of development of disordered eating. At the moment, however, it is very unclear how risk factors interact with each other or at which developmental stage a risk factor is most potent. While more research is required to clarify these issues, there is sufficient evidence to indict cultures and subcultures which promote an unhealthy, thin beauty ideal for women as the path to happiness and success to indicate that prevention activities must be directed at the wider community, not just the individual.

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Chapter 4 – Issues in the prevention of eating disorders and disordered eating

Eleanor H. Wertheim

Prevention approaches are most often described as taking three forms: primary, secondary, and tertiary (Levine, 1999; Levine & Smolak, in press). In addition, some theorists discuss prevention in terms of whether it is selective versus universal, and how targeted or indicated it is (World Health Organisation, 1997; Mrazek & Haggerty, 1994, cited in Sanders, Gaskill, & Gwynne, 1998). In this chapter, these approaches will be discussed and applied to the area of preventing eating disorders.

Primary prevention involves efforts to reduce the number of new cases (or 'incidence') of a disorder such as anorexia nervosa or bulimia nervosa or of associated problems such as unhealthy weight loss behaviours including strict (or 'crash') diets, self-induced vomiting, or use of laxatives, enemas or diuretics to lose weight. Usually, this aim is accomplished by identifying the 'risk' factors predicting the development of the disorder (e.g., being in a social environment which promotes dieting or having a higher body size than the norm) and then reducing those risk factors. Primary prevention can also involve increasing 'protective' factors that reduce an individual's vulnerability to developing the disorder (e.g., increasing social skills or the ability to critically evaluate media images portraying underweight models) or changing the environment so it is less pathogenic (e.g., changing the images of beauty presented in the media).

Secondary prevention involves focusing only on individuals who show signs of developing a disorder, and preventing those symptoms from becoming worse or developing into an actual eating disorder. Secondary prevention involves: 1) encouraging early identification of incipient eating problems, 2) providing information about what to do about these signs at an early stage, and 3) developing effective early intervention programs. Early identification processes might include educating individuals such as teachers, health professionals, parents, or peers, particularly in high risk environments, about the early signs in people who are developing an eating disorder. The second step involves providing information about how to discuss the problem with the individual who appears to be at risk as well as resources for dealing with the problem including referral information. Finally, secondary prevention involves developing and evaluating interventions for preventing the development of eating disorders and for decreasing problem behaviours at this early stage (targeted prevention).

Finally, tertiary prevention is similar to standard treatment or rehabilitation approaches in which the focus is only on those with an actual eating disorder. In tertiary prevention, individuals with eating disorders are encouraged to take part in treatment at an early stage, in order to prevent the disorder from becoming chronic. The same three steps as for secondary prevention are relevant: 1) enabling early identification of individuals with eating disorders, 2) disseminating information about what to do about the problem, including how to encourage the sufferer to seek help, and 3) developing and evaluating effective treatment programs.

It is argued that a comprehensive prevention approach needs to include all three forms of prevention. Nonetheless, the major focus of this chapter will be on primary and secondary approaches.

Why should efforts be made to prevent eating disorders and associated behaviours?

Several types of research findings have led to calls for work into the prevention of eating disorders and associated behaviours (see Russell & Beumont, 1995; Slade, 1995). First, although it may not be true that eating disorders are at 'epidemic proportions', the disorders are relatively prevalent in developed societies including Australia (see Chapter 10 by Beumont). In addition, the associated behaviours, such as strict dieting, fasting, binge eating, and body dissatisfaction, are much more common in the population (see Chapter 1 by Sanders & Gaskill). Eating disorders have numerous unhealthy side effects affecting the skeleton and teeth, fertility, and cardiovascular, renal, endocrine and gastrointestinal functioning (Treasure & Szmukler, 1995). The mortality rate due to suicide or complications of starvation, particularly for those with anorexia nervosa, is high (Slade, 1995; Treasure & Szmukler, 1995). Even at only subclinical levels, the subthreshold eating behaviours and body concerns, which are very common, are associated with considerable distress in sufferers, such as increased levels of depression, and reduced health or nutrition (Brownell & Rodin, 1994; Gibbons, Wertheim, Paxton, Szmukler, & Petrovich, 1995; O'Dea, 1995; Patton, Johnson-Sabine, Wood, & Wakeling, 1990).

Furthermore, an increasing body of longitudinal research indicates that dieting behaviours and disordered eating which are reported in early adolescence are maintained over time (e.g., Attie & Brooks-Gunn, 1989; Leon, Fulkerson, Perry, & Early-Zaid, 1995; Keel, Fulkerson, & Leon, 1997; Wertheim, Koerner, & Paxton, 1999). It appears, then, that in many young people, an over-concern with shape and weight, and unhealthy dieting or eating practices do not simply go away without intervention.

Eating disorder treatments are generally lengthy, and relapse and a subsequent need for further treatment is common. In addition, a shorter duration of illness has been found to be associated with a better outcome from treatment in some studies (Steinhausen & Glanville, 1983; Herzog, Keller & Lavori, 1988). Therefore treatment of eating disorders is expensive to the community and primary or secondary preventative approaches can be argued to be sensible alternatives in terms of cost-effectiveness.

Findings from prevention programs assessed to date

Increasingly, researchers and practitioners have been calling for studies into the prevention of eating disorders. Yet, while a range of primary prevention programs has been assessed to date, the field is still in its infancy. A variety of programs have been attempted, ranging from brief videotape interventions, to full programs lasting many weeks or months. Most programs have targeted adolescent females (Carter, Stewart, Dunn & Fairburn, 1997; Heinze, Wertheim & Kashima, in press; Killen, et al. 1993; Moriarty, Shore & Maxim, 1990; Moreno & Thelen, 1993; Neumark-Sztainer, Butler, & Palti, 1995; Nichter, Vuckovic, & Parker, 1999; Paxton, 1993; Phelps, Dempsey, Sapia & Nelson, 1999; Piran, in press, cited in Piran, 1999; Rosen, 1989; Shisslak, Crago & Neale, 1990), with lesser numbers targeting primary school aged students (Huon, Roncolato, Ritchie, & Braganza, 1997; Smolak, Levine & Schermer, 1998a,b), or beginning university students (Huon, 1994; Mann, Nolen-Hoeksema, Huang, Burgard, Wright & Hanson, 1997).

An overview of these studies indicates that researchers are still not clear about what the most effective approach to preventing eating disorders is. A range of studies have successfully increased knowledge in students and it is argued that this increased knowledge is a necessary, but probably not sufficient, component of prevention (Murray, Touyz & Beumont, 1990; Piran, 1995). Some of the programs have found short term changes in attitudes and behavioural intentions, but these changes are often not maintained at follow-up. A few studies have found maintenance of specific types of positive attitudinal and behavioural changes at follow-up (e.g., Moreno & Thelen, 1993; Neumark-Sztainer, et al. 1995). In general, studies have not actually demonstrated that eating disorders per se were prevented (possibly excepting Piran's, 1999, work in a dance school); partly because baseline rates for clinical eating disorders would require larger sample sizes than are usually employed. Nonetheless, decreasing eating disorder related attitudes and behaviours is a worthy goal in its own right, given the concerns noted previously.

To date, it is not clear which approaches are most effective, or why there are different outcomes in different studies. One of the major reasons for this lack of clarity is that most studies have not approached prevention research from a systematic basis. Studies to date have included a package of interventions which were sensibly derived from what is known about the causes of eating disorders and theories related to risk factors. However, generally, interventions were compared only to one non-treatment control group (or in some cases to no control) rather than to alternative treatments or treatment components. So reasons for relative success or failure of a program are not clear. Systematic research is needed based on what is known from general psychological processes related to attitude and behaviour change. Specifically, well-controlled research is needed into who the most appropriate recipients of programs are, what the most appropriate message contents are, what the most effective channel(s) or method(s) of communicating these contents might be and from which sources the preventative messages will be most effective (McGuire, 1985; Pritchard, 1986).

Who should be the target recipients of prevention programs?

This section will first address the general importance of risk status of the recipient, drawing the distinction between universal, selective, and targeted or indicated approaches. Then two examples of types of risk status will be discussed briefly, age of recipient and gender (while acknowledging that many other important recipient characteristics exist, such as participation in certain physical activities, ethnic background or various psychological characteristics). Finally, the issue of targeting specific groups of people, such as peers, parents, media and helping professionals, who influence those at risk, will be addressed.

Risk status of the recipient (universal versus selective prevention)

Within the primary prevention approach there are two main subcategories: 'universal' prevention and 'selective' intervention (Levine & Smolak, in press; World Health Organisation, 1997). A universal prevention approach (or 'public health prevention') would attempt to change the general population, for example through public health laws or broad health promotion media campaigns. A selective prevention approach would target individuals who, although they do not display symptoms of an eating disorder, are considered at risk due to personal characteristics or characteristics of their environment. A final category, 'targeted' prevention (World Health Organisation, 1997) or 'indicated' prevention' (Mrazek & Haggerty, 1994, cited in Sanders, Gaskill, & Gwynne,1998) moves further towards secondary prevention in that individuals who have made steps along the path but do not have actual symptoms of eating disorder may be targeted as well as those who are showing early signs of an eating disorder (such as subclinical extreme dieting behaviours or binge eating). There are both advantages and disadvantages in targeting only individuals who are demonstrating early risk signs, although targeting high risk environments may be generally a good idea.

An advantage of a selective or targeted approach is that it is potentially more cost effective as resources are selectively allocated to those most at risk. Nonetheless, particularly when selecting out specific individuals for intervention (e.g., encouraging individuals who diet to attend a special program), there are some disadvantages. For example, in school settings educators may be reluctant to label and identify individuals as high risk or demonstrating initial symptoms suggestive of early stages of an eating disorder. Labelling may have unhelpful or iatrogenic effects, first by leading the individual to identify him or herself as abnormal and second, through the stigmatising effects of singling out certain individuals. In order for such an approach to work, care needs to be taken about how to label the intervention and those who are targeted to avoid negative effects. Where broad classes of higher risk individuals are involved, such as all students in a dance school or all Grade 7 females, there may be less risk compared to singling out certain individuals. Thus it may be more appropriate to provide targeted primary prevention interventions for broad classes of high risk groups.

A possible danger of targeting more universally, is that individuals who have not yet developed early symptoms such as dieting may be exposed to new ideas which might inadvertently promote unhealthy behaviours. Sanders and colleagues (1998) addressed this issue by recommending that the degree of risk and costs acceptable in a program should be dependent on how certain one is that the person is truly 'at risk' of the disorder. That is, more intensive interventions including discussion of eating disorder pathology may only be warranted in indicated, secondary or tertiary prevention. This issue will be considered further later, and would need to be carefully addressed in any universal intervention approach.

A distinction should also be made between 1) who participates in a prevention program, 2) who is targeted in that program and 3) how the data is analysed. For example, most programs to date have involved classroom interventions in which all students take part. Nonetheless the interventions are generally designed with high risk individuals in mind. Therefore, such interventions must be designed to 1) effectively prevent disorders in high risk individuals and at the same time 2) do no harm to low risk individuals. Risk status can be defined in various ways (e.g., pre-intervention body size, drive for thinness or body concerns) depending on the risk factors the intervention is designed to address and predictors of eating disorders. When both high and low risk individuals attend the same intervention, subsequent statistical evaluation of the program should still separately analyse the outcome for the different risk groups, rather than combine the various groups into a general sample for purposes of analysis.

Age of recipient

The ages of highest risk for the development of eating disorders are generally reported to be around puberty (when onset of dieting is common) and then again in later adolescence (when binge eating may emerge) (American Psychiatric Association, 1994). Nonetheless, recent studies have indicated that certain attitudes associated with disordered eating, such as anti-fat attitudes and body concerns and even dieting, can begin earlier than puberty (Smolak, Levine, & Schermer, 1998b; Tiggemann & Wilson-Barrett, 1998).

Optimally one would time prevention interventions to occur prior to the development of dieting behaviours. For example, Neumark-Sztainer, Butler & Palti (1995) found that their prevention program was not successful in decreasing dietary restraint in adolescents who had already initiated unhealthy weight loss behaviours, but they were able to reduce the onset of new dieting behaviours in those who had not already experimented with them. Thus, preventing onset of unhealthy weight loss behaviours may be a better goal (primary prevention). However, the advantage of this approach must be balanced by ensuring that the recipients see the messages as relevant to them. That is, those who have not yet developed a drive for thinness may perceive the messages as personally irrelevant and fail to attend to them (Petty & Cacioppo, 1986).

A further consideration in planning timing of interventions involves the danger that individuals who have not yet experimented with unhealthy weight loss behaviours may be accidentally encouraged to do so. For example, a discussion of strict dieting or vomiting may inadvertently increase the likelihood that recipients will engage in the newly discovered behaviours, either through initiating the ideas or normalising those behaviours. For this reason, some researchers currently advocate that the more extreme behaviours associated with eating disorders (e.g., use of laxatives or self-induced vomiting) not be discussed in primary prevention programs (Rosenvigne & Gresko, 1997), particularly at early ages. It has been argued (Mann, et al. 1997) that secondary prevention (in which, in order to be effective, one may need to discuss specific unhealthy weight loss strategies) should not be combined with primary prevention. While this may be the case, some researchers have given details about eating disorders in primary prevention programs without any apparent negative effects (e.g., Moreno & Thelen, 1993) and there is very little evidence that any negative effects have been long lasting. To date, insufficient research has been conducted on the problem. The issue may be more one of how and when the material itself is presented rather than whether it is presented at all.

The implication of these issues and findings is that prevention must be applied in a developmentally appropriate manner across different ages (Attie & Brooks-Gunn, 1992; Friedman, 1996; Heatherton & Polivy, 1992; Shisslak, Crago, Neal, & Swain, 1987). Researchers need to assess the most effective time point for intervening with particular preventative strategies.

Gender considerations

One in ten persons with an eating disorder is male (American Psychiatric Association, 1994). Given that males are such a small percentage of the eating disorder population, the question arises as to whether prevention efforts in males are warranted. Indeed with limited funds, females might be considered the most cost-effective group to target. Nonetheless, there are two advantages of targeting not only females, but in some way to also target males. First, by targeting males, those at-risk males will hopefully avoid developing a disorder. Cross gender prevention programs would need to be carefully planned, since many of the current programs include female specific information and at least one researcher has indicated that cross gender classes may result in boys, through lack of interest, disrupting discussions of interest to girls (Neumark-Sztainer, 1996). Second, while boys do not develop eating disorders as often as girls, they do play a role in perpetuating attitudes regarding unhealthy body ideals and negative stereotypes of fatter people. Thus they are also part of a broad sociocultural environment that supports the development of eating disorders in both genders. Preventative approaches discouraging males from teasing fat individuals, or selectively attending to thin females could help to overcome such stereotypes.

Groups who potentially influence individuals at risk of developing eating disorders

It is clear that eating disorders are not simply caused by characteristics of individuals. Eating disorders occur in a sociocultural context. Environments and cultures which stress maintaining a thin body (e.g., ballet schools, gymnastics programs), where dieting behaviours are encouraged, or where fat is stigmatised have been found to have increased prevalence rates of disordered eating behaviours or eating disorders (Attie & Brooks-Gunn, 1992; Russell & Beumont, 1995). Therefore, it is likely that a simple prevention program aimed at changing an individual's attitudes or behaviours in isolation would not be completely effective.

It is more likely that individually focussed interventions can play an important role, but that support for a new cultural context is needed from many levels. Multidimensional, community interventions have been recommended as promising, based on some of the more successful prevention programs in the field of cigarette smoking (Levine & Smolak, 1998). These multiple dimensions would include not only preventative education for children or adolescents, but also changes within a school environment, parent education and involvement, and positive media coverage in support of the program. These immediate sociocultural influences, such as family, teachers and peers are important to target both at a primary prevention level and a secondary prevention level. They not only transmit broad sociocultural values about weight, body size and eating behaviours to a child but can also detect early signs of an eating disorder and provide information about how to respond appropriately.

In relation to parent involvement, children and adolescents who are dieters are more likely to have parents who encourage them to diet or lose weight (e.g., Wertheim, Martin, Prior, & Sanson, In press; Wertheim, Mee, Paxton, & Muir, In press). Thus, parent education and involvement may be an important element of a prevention program.

In addition, school environments differ, with some schools having relatively higher prevalence rates than others (Paxton, Schutz & Wertheim, 1999). Therefore, it may be important for a whole school to join in supporting an environment which minimises influences leading to eating disorders (comparable to the 'whole-school' approaches used in anti-bullying programs). School influences are likely to include whether school staff condone or discourage negative comments about peoples' weight or shape, policies about athletic activities, particularly those that may be affected by weight, and the types of food provided in cafeterias. A whole school approach would involve supporting and training teachers of different disciplines, health care providers, counsellors, athletics coaches and food service providers (Neumark-Sztainer, 1996).

A complete prevention approach would also target broader, more distal, sociocultural influences, such as the media and the fashion industry. The media are major sociocultural influences which help to shape attitudes about body shape and size and also provide information about weight loss methods. There is clear evidence of increasing normative pressures to be thin over past decades as evidenced by increasingly slim models and the number of articles promoting weight loss diets (O'Dea, 1995). Preventative action can take two main forms in this context. First, individual recipients can be taught media literacy skills to interpret these media influences in an adaptive manner. Second, the media industries themselves can be encouraged to change the images they portray through education, advocacy, and in some instances legislation (e.g., laws related to truth in advertising).

The fashion industry also has been viewed as playing a role, through the fashion models it uses and the clothing designs it offers. For example, adolescent girls report that they feel pressured to lose weight to fit into the clothing offered in mainstream shops (Wertheim, Paxton, Schutz & Muir, 1997). An increased awareness of the large marketing power of average and larger sized women can lead to the fashion industry offering a greater diversity of fashions. Advocates can stress both the ethical and economic advantages to the fashion industry for changing norms.

Preventative interventions are also appropriate for helping professionals including health professionals. A study of women with bulimia indicated that many who had discussed their problems with medical practitioners had found the discussion unhelpful (Wertheim & Weiss, 1989). Therefore, the dissemination of information related to appropriate identification, advice and referral would be of use for helping professionals in general, and for health professionals in particular. Two recent reviews (Noordenbos, 1998; Weiner, 1999) have suggested that medical practitioners can play an important role in secondary prevention, by improving their ability to identify eating disorder behaviours at an early stage, and by changing their attitudes and communications with those patients. Early identification can include noting physical signs suggestive of purging behaviours or starvation (see list of signs of adolescent eating disorder in Katzman, 1999) or parent or child behaviours suggestive of overconcern with body shape or eating and dieting behaviours (see list of signs in Weiner, 1999). Patients can also be encouraged to discuss eating concerns and helped to identify eating disorders, e.g. by leaving brochures on the topic in the waiting room.

In addition, primary prevention can be undertaken by educating health professionals to avoid inadvertently encouraging behaviours likely to increase the risk of disordered eating, such as recommending weight loss diets, prescribing appetite suppressants, or casually suggesting that a patient lose weight. Health professionals can aid in the education of parents to raise healthy children through discussion of nutrition, physical activity, and normal development (Weiner, 1999) and can offer useful advice to patients about body and eating concerns.

What should be the content of prevention programs?

Approaches to prevention can be categorised into three broad areas: 1) a general competence enhancement approach (based on a 'non-specific life stress model', Levine, 1999), 2) a specific eating and body related risk factor approach (based on a 'disorder-specific continuity model', Levine, 1999) and 3) a social feminist approach. To date most programs have included either a combination of the approaches or have stressed providing information related specifically to eating and body concerns.

General competence enhancement approaches.

Some researchers advocate a general competence based approach to prevention, which involves building skills to enhance protective factors for a variety of mental health problems. These skills might include, for example, self-esteem building (e.g, O'Dea, 1997), self-identity development (Franko & Orosan-Weine, 1998), social skills enhancement, stress management, or the ability to critically analyse media messages (Levine, Piran & Stoddard, 1999).

A general competence enhancement approach assumes that certain general, non-specific protective factors exist such that individuals placed in a risk environment, but armed with those protective factors will be less likely to develop eating (and other) disorders. The approach has advantages in being potentially more cost effective, in that a larger number of individuals can be targeted at any one point in time. That is, not only would the intervention be relevant to individuals at risk of eating disorders, but it would also be relevant to those at risk of other psychological disorders. If effective, a general competence building approach has the further advantage that it avoids inadvertently encouraging unhealthy weight loss strategies or over concern with shape and weight, since such behaviours and attitudes would not be directly addressed. Furthermore, individuals would not be singled out as at eating disorder risk by participation in such a generic program, which is likely to be universally applicable. To date, however, it is not clear whether general competence building approaches are effective in specifically preventing eating disorders and how well these broad skills generalise to eating and body related contexts.

Specific eating and body related risk factor approach

A contrary view would derive from the etiological model which indicates that it is eating and body specific factors which lead to the development of eating disorders. For example, of all the research evidence in the eating disorder field, some of the strongest evidence is for the dietary restraint model, which indicates that strict dieting is a risk factor for developing eating disorders (Heatherton & Polivy, 1992). Therefore, it is likely that somehow tackling the problems associated with weight loss diets, providing information about why diets often do not work in the long term, and providing alternative approaches to dieting, may be very important for prevention programs. The most effective way to do this is yet to be found; however, the strong links between dieting and later eating disorder development indicate efforts should be made to introduce and discuss such material in health promoting ways.

It is most likely that the more effective approach would be a combination of (1) general competence building approaches, for example, through personal development streams in schools, and also (2) providing specific information and skills related to healthy weight maintenance strategies and acceptance of a diversity of shapes and sizes in our culture. In addition, regardless of whether the skills and information taught are general life skills or specific to eating disorders per se, a recent review suggested that programs incorporating life skills components are having somewhat better outcomes than those that are purely didactic (Levine & Smolak, In press).

Social feminist approach

A final approach has been noted by several authors (Levine and Piran 1998; Steiner-Adair & Vorenberg, 1999). This approach suggests that eating disorders and associated behaviours develop as a result of a sociocultural environment promoting weightism (prejudice against fat) particularly in women. The argument is that issues regarding weightism should be recast as social justice issues rather than individual risk issues. Levine and Piran (1998) further argue for a 'Feminist-relational-empowerment' paradigm, saying that individuals' experiences of their body are influenced by social structures, prejudices and mores and that this needs to be addressed in prevention interventions.

What are the most appropriate message contents to include?

Examples of message areas and content used in many of the prevention programs to date include: information about normal pubertal changes related to body size and shape, genetic determinants of weight and shape, the historical and cultural context of the thin body ideal, how to interpret media messages about thinness, the dangers of weight loss diets, methods for healthy weight regulation, information about eating disorders, risk factors for eating disorders, discussions about peer influences, family pressures and sociocultural influences, and general life skills enhancement. The content of programs has been derived from theories of the development of eating disorders.

Griffiths and Farnhill (1996) compiled a series of messages providing advice for those who care for children and adolescents. These messages (adapted and displayed in Table 1) provide a good summary of the sorts of messages that are advocated by prevention researchers.

Table 1

Proposed advice for preventing eating disorders for parents and others who care for children and adolescents (adapted from Griffiths & Farnill, 1996).

1. Avoid encouraging young people to diet or lose weight. Communicate affection and concern irrespective of the person's weight or shape.
2. Avoid commenting on people's weight or shape. Encourage others to feel good about and accept themselves.
3. Be a good role model by not criticising your own body, or dieting, or talking about diets and physical appearance.
4. Help children understand that weight gain is a normal and necessary part of pubertal growth.
5. Educate young people about the dangers of prolonged or strict dieting and point out that caloric restriction may actually result in overeating and weight fluctuations.
6. Educate young people to counteract advertising that makes them feel inferior or promises magic results if a certain "look" is achieved.
7. Assist young people to adopt healthy nutrition practices and engage in enjoyable physical activity at home and in school.
8. If someone wants to lose weight by dieting, discuss what he or she hopes to achieve and possible ways to achieve that without dieting or using unhealthy behaviours.
9. Educate your child by promoting both coping skills and realistic strategies such as problem-solving for dealing with stressful situations. Help your child to recognise that feelings can be confronted, experienced and accepted.
10. Adopt positive attitudes and support for teachers who engage in human development courses. Ask questions about the implementation of school curricula directed to the prevention of dieting disorders.

To date very little research has been conducted on the precise forms that these messages should take. The precise message forms need to be developed in the same way that advertisers develop their persuasive messages, developing and gearing them to particular target audiences. The wording of the messages as well as peripheral cues (e.g., who is presenting the message, how glamorous the presenter is, how similar the presenter is to the recipient of the message) should be examined and tested. An example of this approach is the research undertaken for the Body Image and Better Health Program (Murphy, 1997). Focus groups of women in the target age group commented on a variety of possible messages that would be used in advertising an International No Diet Day and this information was utilised in selecting the message used. Of course, self-report responses to message contents need to be followed by examining actual changes in behaviour following exposure to the messages.

One of the reasons that prevention efforts have not taken place in the media on a large scale is that the specific prevention messages appropriate to eating disorders are not as simple as in some other prevention fields. For example, in anti-smoking campaigns the target behaviour (smoking) is relatively clear and the message is consequently clear: 'stop smoking'. In contrast, the message from eating disorders prevention is less clear since the disorder has multiple determinants, involves numerous behaviours and attitudes and the behaviours are more complex. For example, the message 'don't diet' can potentially be misconstrued since individuals are not always clear about what a 'diet' is. This is not a reason to discard media campaigns which can potentially have a high impact (particularly if combined with other approaches); however, it does suggest that clear messages need to be developed before media approaches can be successful.

Who are the most effective presenters of the information?

An issue relevant to how persuasive a message is, involves which presenters of prevention programs are most effective. For example, experts, teachers, peers, and individuals who have recovered from an eating disorder, all have advantages and disadvantages and have been used in the various preventative programs assessed to date.

Recovered sufferers, peers, and experts

Students and teachers often request to hear from presenters who have recovered from an eating disorder (Huon, 1987; Moriarty et al. 1990; Russell & Beumont, 1995), and recovered individuals often give talks. Similarly videotapes are available in which recovered sufferers tell their stories. While these presentations may increase interest for young people, and former sufferers may want to pass on to others what they have learned, the use of such presenters has been questioned (Carter, et al. 1997; Garner, 1985; Mann, et al. 1997; Smead, 1985). The main concern is that presenters who are former eating disorder sufferers may inadvertently glamorise eating disorders and normalise or encourage such behaviours. In cases where such a presenter has not been well briefed or has not completely recovered from the eating disorder, there is the added danger that non-useful advice might be accidentally offered.

One study found that when a presenter on a videotape was identified as a recovered anorexia nervosa sufferer, it did not lead to more maladaptive eating attitudes or dieting intentions in adolescent girls. However, this was in the context that the presenter did not go into details about her disorder (Heinze, et al. in press). The findings may be different, therefore, in cases where recovered sufferers describe their illnesses more specifically, or in less controlled contexts.

One of the few well controlled prevention studies to date which reported that the intervention group developed more eating disordered symptoms than the control group at post-test included university peer presenters who had suffered from an eating disorder describing their illness and recovery (Mann, et al. 1997). While the differences between groups disappeared after several months, the study offers a caution to program designers. Further research is needed into the circumstances under which presenters, particularly those who have recovered from an eating disorder, may increase or decrease healthy behaviours in others.

Friends and friendship groups can be very powerful in either promoting or opposing thin body ideals and weight loss methods or modelling those behaviours (Paxton, 1996, 1999; Wertheim, Paxton, Schutz, & Muir, 1997). The use of peer presenters has been advocated in several non-eating related prevention fields involving substance abuse (Montagne & Scott, 1993; Oei & Fea, 1987; Tobler, 1986). To date in the eating disorder literature, it is not clear whether peer presenters are more effective than others. In the one study to specifically examine the effect of the presenter being identified as a peer, recipient identification of the presenter as closer to the recipient's own age did not increase the effectiveness of the preventative information (Heinze, et al. In press). Nonetheless, the use of peer presenters is worth examining further, although again, peer presenters would need to be well trained or included in well-controlled conditions such as in a videotape.

School interventions have tremendous advantages in that they are able to reach large numbers of children or adolescents at the same time. Although initially research program developers may wish to have experts (such as program developers) run the programs, if the programs are to be considered viable on a large scale they must be designed to be easily applied by and interesting to teachers. This means that the expertise required to run the program must be in the capacity of school teachers without a great deal of additional training or development time required.

The role of non-profit eating disorders organisations

Non-profit organisations specifically designed for eating disorders awareness, prevention and support have emerged internationally and within Australia and play an important role in prevention. Examples in Australia include the Anorexia and Bulimia Nervosa Foundation of Victoria, Ltd. (ABNFV), and Body Image and Health Inc. (BIH). These organisations are usually funded by the government and/ or through grants, membership dues, sales of printed materials, and donations. They generally rely partly on employed staff, as well as lay volunteers to help with clerical work, and telephone and face-to-face support services and professional volunteers to provide expertise. These organisations contribute importantly to prevention (Levine, 1999) through: 1) providing resource lists, materials for use in programs, information about eating disorders, and referral lists, 2) sponsoring conferences and workshops for professionals, and community information days, 3) facilitating networking between professionals and lay volunteers, 4) engaging in activism (political and media targeted) to prevent eating disorders, and 5) promoting multidimensional programs such as the Body Image and Eating Disorders Awareness Week.

What are the most appropriate channels for presenting preventative messages?

Message channel (McGuire, 1985) refers to the medium used to present information or a preventative argument. Channels could be printed media such as magazines, videotapes, television, billboards, computers or in person presentations. No research to date has systematically varied channel controlling message content; however, some brief comments may be in order.

Two studies have examined the use of brief videotapes in high school settings. One included a younger sister having a discussion with her older sister who had written a paper on eating disorders (Moreno & Thelen, 1993). The other study included a single presenter presenting the information (Heinze, et al. In press). Both were promising in producing some change in attitudes and behavioural intention after only a brief intervention. Videotapes have the advantage of being standardised and generalisable across settings. In prevention programs, they can also be used as stimulus material to base discussions upon, which would lead to more recipient involvement than only showing the videotape on its own.

Recently, computer based interventions have emerged as increasingly important in a variety of fields. The internet has allowed the dissemination of information on an international scale. For example, one can access the ABNFV homepage (www.ozdir.com/abnfv/) for information available in Australia including local treatment and referral options. In addition, one can access overseas events and information from international organisations such as Eating Disorders Awareness and Prevention (www.edap.org) in the United States. These resources do appear to be widely used. For example, the ABNFV homepage indicated about 6000 instances of people accessing their site during approximately a one year period. Self-report research indicates that some individuals with eating disorders report using internet based communications as virtual support groups and sources of information (Gleason, 1995; Winzelberg, in press; cited in Winzelberg, et al. 1998).

In addition, several studies have been conducted on an interactive computer program ('Student Bodies') for female undergraduates supplemented with email linked support or discussion groups moderated by a researcher (Winzelberg, et al. 1998; Winzelberg, In press; Zabinski, In press). While the studies to date have found only small differences between intervention and control groups, and compliance of participants has varied across studies, the field has considerable potential.

Future directions for prevention work

It is important to continue work into the prevention of eating disorders and related behaviours. This work involves research, development and implementation.

Regarding research, prevention interventions should be evaluated thoroughly comparing control and treatment groups in relation to both short term and long term changes following the program. Several studies have found initial gains following the intervention, which later dropped off. This pattern does not necessarily indicate that the program 'failed', since additional booster sessions following the program or additional sociocultural interventions supporting the preventative intervention, which would help to maintain gains over time, could potentially be found. Nonetheless, it is imperative that we do know whether initial changes are maintained over time, and which additional interventions help to maintain improvements.

In addition, some researchers have reported that in follow-up after a preventative intervention those who had participated in the intervention program reported more disordered eating patterns rather than less (Carter, et al. 1997; Mann, et al. 1997). One of these studies failed to have a control non-treatment comparison (Carter, et al. 1997), so the finding may simply reflect the normal increase in dieting behaviours that tends to occur with retesting, or over time in adolescence (e.g., Banasiak, Wertheim, Koerner & Voudouris, in press; Moriarty et al. 1990). The second study (Mann, et al. 1997) found that the more maladaptive patterns found after the program disappeared within a few months and were not lasting. Nonetheless, the possibility that prevention programs may actually do harm must be addressed through follow-up with equivalent non-intervention controls.

The interaction between recipient characteristics and the intervention should also be examined. Most important is examining the different impacts on recipients at different levels of risk. For example, certain programs could have a positive impact on those who already display disordered eating behaviours, but no impact or a detrimental impact on those who have not experimented with such behaviours previously.

Specific components of interventions need to be examined and compared, to better understand which aspects of preventative interventions are successful and which are not. To date, almost all preventative interventions have included a relatively large package of strategies compared to a non-treatment control. Even if such a package is 'successful' it is not clear why it is successful. When such a package is not successful, it does not mean that no element of the package has value. Some components of the program may have been useful while others deterred from a successful outcome. It is important that these elements be theory driven and examined systematically.

Putting prevention into practice: Providing skills, motivation and resources

Once research has been conducted into the most effective ways to prevent eating disorders, the findings need to be disseminated and put into place on a large scale. Issues in application include how to most efficiently provide the necessary skills and resource materials to individuals who are well placed to provide preventative interventions and how to motivate them to put the skills and available materials into practice. Robinson and Killen (In press) have provided an excellent description of organisational, individual (e.g., teacher) and program variables that aid successful long term implementation of prevention programs.

And finally we need to be aware that resources are needed. If we really are committed to preventative education then we need to provide resources for that purpose. These resources may include development and distribution of training packages, workshops, instructional materials, and personnel with appropriate training, as well as funding for research into developing and promoting preventative interventions. Needed resources also include funding of organisations that develop and distribute information about eating disorders and treatment options, and who can advocate for social changes which will help to prevent eating disorders. Funding for resources directed towards prevention is likely to be cost-effective in that it can limit the funding needed for expensive treatment for those who do develop full-blown eating disorders.

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Chapter 5 - Advertising and the body as ideal image

Anne Ring

The mass media and cosmetic surgery are complementary beneficiaries of modern technologies that have made the restructuring of the body both a 'reel' art form and a reality. The question, then, is whether the body itself is a winner or a loser in the face of such progress. The facts and figures of contemporary cosmetic surgery and their implications for the body as a lifelong project and as the embodiment of self and identity, are discussed in Chapter 8. This Chapter examines the apocryphal images that are created by the advertising industry as unreal benchmarks for the body.

I am a sociologist and media analyst who has spent much of the past 14 years researching the ways in which the body is presented in the mass media. I have examined the advertising and editorial content of popular men's and women's magazines published since the early 1950s, and I continue to monitor these magazines. Over the past 50 years there have been major social changes in the status of women, as well as in lifestyle, health, and the wide range of technologies that have come to characterise contemporary western society.

During this time there have also been significant developments in the ways in which the body has been presented in the media, especially from the point of view of how images of the female body are used in advertising. These developments have not, however, been in the direction of social change, but more related to technological refinements that have only heightened the physical gulf already evident between the appearance of women in general and of models in particular. This gulf is a favourite topic in the media, particularly as the expanding volume of research reveals its damaging effect on women's self-esteem, and the rise in associated pathological conditions. These conditions range from specific eating disorders and body dysmorphic disorders to disordered dietary practices and what has been described as an epidemic of body image dysphoria (or 'dissatisfaction and anxiety…about one's body') in women in western societies (McGrath, 1994; Ben-Tovim, 1996; Sarwer, 1997; Zimmerman, 1997; Rabak-Wagener, Eikhoff-Shemek & Kelly-Vance, 1998). An estimated two thirds of young women and one third of young men in the United States are, moreover, currently deemed to have a significant level of *dissatisfaction with their body size, shape, condition or appearance* (Rabak-Wagener et al. 1998, p. 29).

One could ask why it is that while women have become increasingly liberated in real life, in the 'reel' life of advertisements their images have become increasingly constricted into a narrow band of perfection. Perhaps we may be entering an era in which men are more at risk of a similar manipulation of their images. In either case, there may be little that can be done to counteract this, in or out of the media. These issues are considered in the course of the ensuing examination of the mass media as context for various levels of advertising.

The growth of the media as a mass market

> *Advertising money pays for most of Australia's media, and one cannot be understood without the other* (Windschuttle, 1988, p. 3).

The media has been described as one of *five powerful forces [that] have convinced women over the years that they're inadequate unless they package and present themselves in certain culturally sanctioned ways* (McGrath, 1994, p. 229). Specifically, there is considerable evidence *for the mass marketing of body images through print media and television advertising [as] a powerful force in creating the 1990s perception of the tall, thin, and toned ideal for women, and the medium-sized, muscular ideal for men* (Rabak-Wagener et al. 1998, p. 29). The antecedents for this come from the wider context of the manufacturing industries' need to create a consumer market for the volume of goods that were unleashed by mass production, early in the 1900s and particularly after World War 1 (Featherstone, 1982; Windschuttle, 1988).

It was advertising, formerly a discrete and informatively structured part of the media, that came to be used as *a means of efficiently creating consumers [by] concentrating increasingly on a type of copy aiming to make the reader emotionally uneasy* (Ewen in Featherstone, 1982, p. 20). The role of advertising has since been variously described as inducing insecurities, and helping *to create a world in which individuals are made to become emotionally vulnerable* [by] *hammering away* [at personal identity, bodily functions, and self-esteem, and] *holding up models of glamorous and fashionable people to make the ordinary person dissatisfied [with their] appearance and lifestyle* (Windschuttle, 1988, pp 203-204). To the extent that women have been, and remain, *the primary purchasers of goods and services in the consumer society*, they are the principle targets of these strategies (McCracken,1993, p. 4). Tthe medium in which this is seen in its most concentrated form is the woman's magazine, which has become *linked inextricably with advertisers*, particularly in the areas of food and cosmetics (McCracken, 1993, p. 66).

More broadly, it has to be recognised that advertising is not only the major source of media revenue, but also *the 'key link' between media organisations and non-media capitalist enterprises* (Bonney and Wilson, 1988, p. 125). It is of relevance to later discussion to note an observation made in the 1960s which pointed to a shift in the balance of power from the public sector to private corporations. Consequently, the behaviour of the latter, including their effective use of advertising to create demand for their products, came to *set the tone for behaviour in the economy as a whole* (Marris, 1962, p. 307).

It is also relevant that, among contemporary media organisations, there are those which span, or which can form alliances across, a number of different types of media. These organisations have the capacity to negotiate what are currently being envisaged as *one-stop advertising buying arrangements* across a range of media interests (McIntyre, 2000, p. 9). This raises the possibility of new heights of conformity in the dissemination of persuasive images, particularly in the light of some of the less public aspects of the relationship between commercial media and their clients.

Advertising: The nature of the beast

> *Once we accept that commercial newspapers of all kinds deliver audiences to their advertisers there can never be complete editorial independence (Bacon, 1994, p. 8)*
>
> Crossing the line in the Los Angeles Times:
>
> *Shaw revealed that the "wall", as US journalists call the division between advertising and editorial, had been breached frequently in recent months. Advertising staff had demanded favourable coverage for certain advertisers (Reed, 2000, p. 13).*

Advertisements are now a familiar part of our everyday environment in all forms of commercial media, as that taken-for-granted component that provides such a substantial part of media revenue and without which they could not survive (Bonney & Wilson, 1988; Windschuttle, 1988; McCracken, 1993). Average consumers of those media sources believe they can distinguish between advertising and features or editorial sections, and tend to appraise the content of each from a different perspective. There is an expectation that advertising is structured in a persuasive way, while the rest, which can be referred to collectively as the editorial section, is structured to inform, to educate or to entertain (Rivers & Schramm, 1973). The lines that are drawn between standard advertisements and editorial items are certainly quite clear.

Commercialised editorials: reading between the lines

In the recent 'cash-for-comment' case involving a Sydney radio station and some of its talkback announcers (Ring, 1999a) it was evident that there is also an unknown amount of what has been labelled covert advertising (McCracken, 1993). This has been defined as *the promotion of products, disguised as editorial material or hidden in some other form so that they appear to be non-advertising material* (McCracken, 1993, p. 4). In a study of American women's magazines, this type of advertising was found to be so frequent that it increased the total proportion of advertising content from approximately 50% up to 95% in some cases, earning these publications the more appropriate title of *women's advertising magazines* (McCracken, 1993, p. 5).

While some instances of the covert side of advertising do emerge into the public eye, the scope of such activities is difficult to gauge since, as Ellen McCracken (1993) suggests in the context of her research into women's magazines, the imperative that underpins their use is secrecy. Her rationale is that *advertisers think that the editorial format gives greater credibility to the claims they made about their products*....*And it is because of this that both editors and advertisers are understandably worried that obvious violations of the appearance of editorial objectivity might call into question other less obvious covert advertising as well*....This is because, ultimately, the primary objective is *to retain readers' trust in the illusion of a publication's editorial integrity* (McCracken, 1993, p. 55).

To the extent that this is the case, there are implications for the feasibility of controlling covert advertising under a process of self-regulation. It raises the question of whether, as Waller (1998, p.29) speculates in the case of the *pathological images* of women in the media, particular types of problematical content should be controlled by legislation. This would depend, in part, on the consequences deemed to be associated with such content. In the case of the overt advertising of cigarettes, for example, the advertisements themselves were found to contribute to a practice that was proved to be a serious health risk (Chapman and Lupton, 1994).

Extra degrees of influence

It is also important to note that a body of research has provided evidence of a more generalised vulnerability of editorial independence to the economic power that advertisers can exert to manipulate editorial content to ensure that products are enhanced and not threatened. The most extensive documentation about this sort of practice was gathered in the 1980s, and showed how threats to withdraw the cigarette advertising dollar from magazines were associated with the latter's suppression of information about the harmful effects of smoking (Warner, 1985; Chapman, 1986; Kessler, 1989; Silberberg & Magnus, 1989). There is now a growing body of research and anecdotal evidence of such activities in every sector of the commercial media (Wolf, 1990; McCracken, 1993; Bacon, 1994; McManus, 1994; Ring, 1999a; Reed, 2000).

The cosmetics, body care and fashion industries are among those identified as exercising a considerable amount of power over the editorial content of women's magazines (Wolf, 1990; McCracken, 1993). One of the key areas in which such power is exerted, is in control over the types of body images that predominate in these magazines. A recent case of such pressure was described by Cyndi Tebbel (1998), a past editor of an Australian magazine, *New Woman*. Not only did her efforts to feature real women of all sizes modelling clothes suffer a backlash from some of our major advertisers and the term 'Fat Girl's Magazine' (p. 71), but it is claimed that *she quit the publication in 1997 partly because the advertisers were turned off by her use of a size-16 model on the cover* (Tom, 2000, p. 2).

Women's magazines have been observed *to ignore older women or pretend they don't exist* (Wolf, 1990, p. 82) and it has been said *that no picture of a woman goes unretouched* in them (p. 82). Wolf suggests that this is due to the need for magazines to *project the attitude that looking one's age is bad because $650 million of their advertising revenue comes from people who would go out of business if visible age looked good* (p. 84).

Whatever the specific advertised product or service, there is some risk that the 'wall' between advertisements about it, and editorials of relevance to it (Reed, 2000), may be penetrated by influence or economic arrangements. The term 'advertising', rather than the more specific one of 'advertisements', is therefore the more appropriate one to use in the title of this Chapter as the context for the issue of ideal body images. It serves to indicate the importance of being aware of the pervasiveness of the advertisers' influence on what we see throughout the mass media. While it is not always possible to discern the extent of this influence, any analysis of the use of ideal body image can realistically be taken beyond standard advertisements to include those editorial features whose content shows them to be a de facto form of covert advertising (McCracken, 1993). The clearest instances are those editorial features that purport to inform about subjects such as fashion, food, diet, health, body care, beauty and, most recently, cosmetic surgery. They do so, however, by using models to display a range of brand-name products (often with prices), and/or services and/or service providers (McCracken, 1993).

Ideal images: The tricks of the trade

> *Cultural standards of beauty have, until recently, evolved slowly. Our great-grandmothers weren't nearly as apt to be slaves to fashion, for example, because they weren't exposed to the frequency and volume of changing images that we are to-day....But that changed with the advent of modern technology and the development of the media, which brought with it the unprecedented opportunity to create increasingly accessible and instant "perfect beauty" images. The media has played a greater role in creating and changing beauty images than any other force in history* (McGrath, 1994, pp 235-236).

The 1990s can be described as an era that was framed by debate about beauty. At the start of the decade social critic Naomi Wolf (1990) saw it principally from a feminist perspective. She argued that *beauty did not exist...as an objective and universal entity* and was, instead, *based on a myth that put women where men wanted them – out of the power structure* (Etcoff, 1999, p. 1). At the end of the decade, psychologist Nancy Etcoff (1999) took a more gender-neutral stance and proposed an opposing theory: *that sensitivity to beauty is ubiquitous in human nature....All cultures are beauty cultures. Every civilisation reveres it [and] pursues it at enormous cost* (p. 1).

Somewhere between those extreme points of view, are the conclusions drawn by the British Social Issues Research Centre (SIRC, 2000). Based on its recent review of research into body image, the Centre suggests that while concerns about appearance and standards of beauty have been identified for every culture, the difference in modern western culture is our degree of concern. Specifically, normal concerns about how we look have mutated into obsessions, largely because of *advances in technology and in particular the rise of the mass media* with its role in setting increasingly unrealistic standards of beauty, especially for women (SIRC, 2000, p. 2).

Whichever view is held, it is clear that the advertising industry has not only used beauty, but has also elevated images of beauty to the pinnacle of marketing devices. And it has done so in ways which go well beyond the reality of the base materials, that is, the people selected to model those images on the basis of their appearance. The following section examines some of the key image-making strategies in current use in Australia, and demonstrates that while there are reasons why women have been, and continue to be, the primary target, men are also increasingly in the firing line. The implications, ethics and legalities of using such strategies are addressed in the later sections of this Chapter, as are the realities of contending with these practices in a highly competitive, market-driven economy.

Gilding the lily: From model body to idealised body image

> *Research shows – in Western culture women obtain their self-esteem from being desired, from their body shape, from being thought of as objects of beauty. Men, however, gain self-esteem from achievement, power, status and control* (The Body Shop, 1997, p. 20).

In the context of women's appearance, the term 'model' has become synonymous with the ideal body. The role of the model is to display that body in ways which positively highlight and encourage the purchase of products to enhance the appearance. This role has been variously described in positive and in negative terms. For example, US model agent Eileen Ford is quoted as saying that models *have a positive impact (on women) because they set standards* (in The Body Shop, 1997, p. 22), while psychotherapist Jill Zimmerman (1997) describes them as having the opposite effect, *as bait to lure us into feeling physically insecure* (p. 20).

Both in and through its construction by the mass media, modelling continues to be one of the most highly visible, competitive and sought-after positions for women, but not for men. For a female, to be chosen to display products and services means that she has, for a limited period, satisfied the rigorous standards for each of three dimensions of appearance: beauty, youth and the perfect body. In her book *The Beauty Myth*, Naomi Wolf (1990) pointed out that, despite the advances made in equal opportunity and job diversity, the career of model remains one of only two professions (the other being prostitution) *in which women consistently earn more than men* (p. 50). Consequently, despite the criticism levelled at this *display profession* from various sectors of the community (Wolf, 1990, p. 27), modelling is still seen as a pinnacle of success. It is rewarded by money, celebrity status and stellar partnerships with men who are high profile leaders in their fields of business, sport and other areas of achievement.

At the top of this pinnacle are the supermodels and, in a recent initiative to boost women's self esteem, they were targeted by a commercial retailer aiming to promote a healthier body image. The message was: *There are 3 billion women who don't look like supermodels and only 8 who do* (The Body Shop, 1997, pp 14-15). Encouraging though this message might be, it was less than accurate, on a number of counts that are worth considering in the context of the contemporary transformation of real models with ideal bodies into the ideal body images that we see today.

A quick review of any commercial medium will show that the figures are wrong and that, amongst those three billion women there are considerably more than eight who not only look like the supermodels but who also actually work as models. In an examination of a sample set of the *Australian Women's Weekly* published in 1988, 71% of 213 women who featured in the advertisements were classified as models, as were 27% of the 683 women in the editorial section (Ring, 1996). One of the defining characteristics of this classification was the element of anonymity. They were:

Those people who are unspecified by name or are minimally acknowledged by first name and are solely employed as an advertising or modelling or display "vehicle", [or] to enhance something that is being featured in an ad or ed item (Ring, 1996, p. 411).

From this perspective, the real difference between supermodels and the other models is that supermodels have gone full circle in a sense, and managed to regain their identity. The rest, while remaining anonymous, continue to populate the pages of magazines and other print media, television screens, and a variety of other mass media, with bodies that are still conforming to *that tall, thin, and toned ideal for women* (Rabak-Wagener et al, 1998, p. 29).

The photographs of both supermodels and the other models used in advertising have a number of features in common. On average, their bodies, purported to be ideal, are considerably slimmer, almost *waif and whippet* thin (Cooke, 1997, p. 170), and are regarded as more perfect than the average body (SIRC, 2000). In addition to this level of unrealistic role modelling, their photographs are routinely enhanced using increasingly sophisticated technologies to the point where the models not only look far better in the photographs than they do in real life, but have also been transformed into unrealistically perfect images (Cooke, 1997; Bentley, 1999). So we have literally idealised images of women who were originally selected for their unreally ideal characteristics. The comments of a current supermodel, Cindy Crawford, are salutary in this regard. As well as wishing she was *naturally thin like Kate Moss,* [she] *has noticed tell-tale lines of ageing on her face and praises the computers which are able to touch up her photos.... "Thank God for retouching, that's what I say"* (in Anon, 1998, p. 7). The accompanying illustration from a recent edition of *The Courier-Mail* (February 3, 2000, p. 3) has another supermodel juxtaposed with her idealised image.

Supermodel Naomi Campbell standing up against her own image (from the Herald and Weekly Times Photographic Collection)

Making comparisons that are relatively odious

While ideal body images that are optimally enhanced are the most commonly used way of promoting the putative benefits of products and services to improve appearance, another popular strategy involves the use of comparisons. There are two main types, one using ideal models and one with 'real' people. The former commonly involves the comparison of a putative product user versus non-user, in which the user-model is invariably far better looking than the non-user-model. The primary message is that use of the product contributes to great looks. In addition, there are sometimes subsidiary messages which are integrated to show the linkage between great looks and some social value, such as success in any one of a number of areas, from relationships to career advancement, or just being a good, or better person.

With 'real' people, one of the more common promotional devices is the use of before-and-after pictures of the same person. These purport to show how different that person looks as a consequence of a particular intervention, and are used to demonstrate the benefits of everything from hair colouring to weight loss programs and, most recently, cosmetic surgery. Some reasonable doubts are cast on the actual merits of these putative benefits in the face of consistent findings that such pairs of pictures typically include at least one additional difference resulting in enhancement of the 'after' picture beyond the changes produced by the intervention being promoted. Examples that emerged from a recent analysis of a number of cosmetic surgery magazines, included the following list of *potentially deceptive differences:*

- *The expression on the face*
- *The make-up used, including whether, what sort and how much*
- *The hair style*
- *The clothes worn*
- *The posture of the body*
- *The amount of body shown*
- *The presence or absence of 'trouble spots' drawn onto the body*
- *Background lighting*
- *Colour or tone of the picture – from subtle differences in shading to the use of colour versus black and white* (Ring, 1999b, p. 21).

In addition to detectable differences such as these, there is also the possibility of changes through *digital imaging where anything is possible, where blemishes vanish and short, plump people stretch into tall, slim bodies* (Bentley, 1999, p. 1). The total effect of the application of these tricks of the trade can make the actual change from the featured intervention almost irrelevant. It is, ultimately, the enhanced image that is the critical factor.

Doing a number on models and role models

It is relevant to note that the importance of image is additionally reinforced by women's magazines through an editorial variant of before-and-after pictures. This is achieved by featuring models and other ideal role models from the world of entertainment, in ways that reinforce their value as ideal images rather than as real people. This is typically done in association with disparaging text such as *stars without make-up: beautiful one day, tragic the next* and *from big-haired '80s shockers, to sleek and sexy glamour queens* (NW, 2000, p. 16) with the aid of hair stylists, make-up and cosmetic surgery. In this type of feature, therefore, the worth of the role model is linked to the use of appropriate cosmetic products and services.

The pros and cons of tokenism: being seen to be making much of 'real' bodies

> *14 and fabulous – the average woman in Australia is a size 14. With more shops stocking larger sizes now, women who aren't perfect 8s, 10s and 12s no longer have to feel left out.*
>
> [A fashion feature (with covert advertising) using a large-sized and very attractive model (in Woman's Day, December 11, 1995, pp 28-31). It is in sharp contrast to this magazine's usual fashion features, which focus on aspects of style, not the body, and use typical (ie slimline) models: eg in a '*Some like it hot*' feature, referring to clothes in 'wild and vibrant…colours' (in Woman's Day, November 22, pp 44-47].
>
> *Get out and live…Working for a diving school, fifty-two year old Julie Lee faces the sun every day.*
>
> [An advertisement for a moisturiser, accompanied by a picture of an attractive, older woman with a few discrete lines around her eyes, in a boat (in The Australian Woman's Weekly, February 2000, p. 258].
>
> *Your heart is never too old to become younger.*
>
> [An advertisement for a breakfast cereal, accompanied by a picture of a coyly posed, slim, attractive and naked mid-40s woman (in Woman's Day, February 7, 2000, pp 36-37).

A recent magazine featured the stories of two model sisters, *one a slender size eight, and the other a full figured 16* (Anon, 1999, pp 16-17). While the article was very positive about both, it was the sister who was much thinner than the average woman who was considered to be the average model. Conversely, it was the sister who was only slightly larger than the average woman who was the 'super' or 'plus' model, and participated in talk shows as 'an advocate for plus-sized women'. It comes as no surprise that while the larger-sized sister was quoted as saying that she *wouldn't turn down the chance to be a size eight*, her slim sister expressed no interest in being a size 16. This article typifies the tokenistic way in which 'real' looking models are presented, in both the advertising and editorial sectors. They are used relatively infrequently, and instead of being treated simply as models, the accompanying text tends to patronise the body type, while being self-congratulatory for giving it coverage, whether it is size, age or some other population norm and model 'abnorm'. At the same time, as would be expected, what the token models share with models in general is their position at what is described as the *freakishly beautiful* end of the appearance continuum (Hawkes, 2000, p. 24).

In another variant of tokenism, the value and needs of real bodies are addressed in the text of articles which are inappropriately illustrated by photos of typically slimline, unlined models. A recent example from an article covertly advertising swimming costumes, featured manufacturers' responses *to demands for body-enhancing cossies, with designs to shape the woman with a fuller figure* (Koremans, 2000, p. 12). In the accompanying photographs, however, a model whose figure was anything but fuller, displayed the costumes.

In her humorous exposé of the beauty industry, Kaz Cooke (1997, p.176) advocated writing to magazines if we want bigger models, so it is interesting to observe the type of letters published by magazines, and how they reveal the way some readers react to the various types of tokenism described. Two examples are presented below, showing quite different perspectives.

> From: Letters Page of New Woman:
>
> REALISTIC MODELS
>
> *Please, oh please, if you're really the magazine for the new woman, can we see pictures of women we can all relate to? I'm constantly amazed (and angered) to see glossy photos of young, gorgeous, flawlessly made-up models accompanying articles on how to feel good about yourself. The constant barrage of these unrealistic images from the media is one of the reasons many women have low self-esteem. Your magazine is better than most, however you still practice this particular brand of hypocrisy* (Sue Plater, 1994, p. 162).
>
> From: Letters Page of Harper's BAZAAR & Mode:
>
> *I can't believe you chose to put Lauren Hutton on the cover of the magazine. A timeless beauty she may be but do we really want to be reminded of the fact? I've always thought fashion magazines were about dreams and interpreting fantasy. I mean, that's why Ita magazine never really got going, isn't it? It was too real. We all live with the reality of getting older every day of our lives. You don't want it appearing in your dreams as well* (Fiona Jones, 1998, p. 28).

If the wheel ain't broke, why fix it?

Advertising is seen as a conservative anchor on the media. Referring to women's magazines in 1993, for example, McCracken (1993) noted that:

> [because they have been] *immensely successful in selling both copies of the magazines and the products advertised inside…with messages that conflate desire and consumerism,…millions of women are likely to be addressed by these structurally similar messages well into the next century* (p. 2).

Evidence that her prediction is coming to pass is seen most clearly in the growth of new general interest women's magazines. These use the same old tactics to play on women's insecurities, and ensure that women continue to provide the huge market for the body and cosmetic products that are an entrenched part of western economies. The developments that are seen involve the exploitation of contemporary fears and priorities, resulting in the emergence of new catch phrases such as *anti-ageing* (Ring, 1999c, p. 10), and the replacement of the traditionally healthful life message of *feel good look good* by the more profitable sequence *of look good feel good* (Ring, 1999b, p. 22).

Beyond the conventional women's magazines, however, it is relevant to see how McCracken's prediction of the continued viability of the proven commercial approach appears to be underpinning other developments in the world of Australian magazines. These developments are directed at accessing new markets, and/or at marketing new products and services through a medium that Australia appears to have embraced with particular enthusiasm. This enthusiasm has earned it the reputation of having the highest per capita magazine readership in the world (Kiely, 1992). Currently, we have:

(i) The publication of a new wave of magazines, principally targeting women and dedicated to the promotion of cosmetic surgery. The timing of these magazines coincides with the deregulation of advertising by doctors, as a consequence of the National Competition Policy. This has enabled the production of editorials and of advertisements featuring and naming specific doctors. The same doctors are often promoted in both areas within the same magazine (Ring, 1999b, 2000). Aspects of these magazines are described more fully in Chapter 8, including their extensive use of both ideal models and enhanced before-and-after pictures. One of these magazines has now established a version in the United States, which, remarkably, had *not previously had an equivalent magazine dedicated to this subject* (Ring, 2000, p. 3).

(ii) The publication since 1996 of the Australian version of Barbie (Sanders, Gwynne & Gaskill, 1998). This magazine, which first appeared in the United States in 1983, is seen both there and here (McCracken, 1993; Sanders, Gwynne & Gaskill, 1998) as extending the programming of females as life long consumers by going beneath the teen magazine market. It explicitly targets *even younger girls – 4 to 11 year olds – [with] a magazine…that promotes the company's dolls and accessories along with sex roles and ideals of fashion and beauty* (McCracken, 1993, p. 135).

(iii) Men being increasingly seen as an important new market for the appearance industries that have traditionally focussed on women (Wood, 1989; Macken, 1993; Bagnall, 1996). It is considered to be as a consequence of this development that there has, in recent years, emerged a plethora of new magazines for men. Specifically, they are described as vehicles *in which advertisers can attempt to convince* [the] *man he needs both a fragrance and a sports car. And new Italian shoes* (Close, 1997, p. 5). However, while advertising is starting to *use well-built male bodies* to promote both men's and generic products,

> *the cosmetic companies still treat the men's market cautiously*, (Bagnall, 1996, pp, 18,19). As the fashion coordinator for one of the new men's magazines has pointed out, *normal, everyday blokes* react against male models who look like models (Berry in Gare, 2000, p, 6).

In addition, a number of the longer established women's magazines, such as The Australian Women's Weekly, The Woman's Day, New Idea and Family Circle, have experimented, with varying degrees of success, with televised versions of, or offshoots to, their magazines, to both promote the magazine, and expand target audiences. The same old strategies, therefore, continue to be used in old and new media because they are seen as still working well, and contributing to the maximisation of profits. Will advertisers ever get a spoke or two in their wheels, or will they just keep on rolling along with no incentive to change?

From the point of view of the consumers, is there a problem?

As previously indicated, the mass media, with its focus on ideal body images, is considered to be one of five powerful forces that have a substantive role in provoking the epidemic of dissatisfaction with the body among women in western societies (McGrath, 1994; Ben-Tovim, 1996). This Chapter has also argued that advertising has had a major effect on the ways in which body image has been used and enhanced throughout the mass media. This is due in part to the fact that not only is the media a force in its own right, but through the 'key link' of advertising, is inextricably linked with the other four significant forces, the industries based on the body and its appearance: cosmetics and toiletries, diet, fashion and cosmetic surgery (McGrath, 1994).

From this perspective, the media can be seen as an integration of the combined power of all five forces, in terms of propagating ideal body images, which could be described as misleading and deceptive when used in advertising. This is a significant issue in the light of the protection that consumers are supposed to be assured under the Trade Practices Act against advertisements that *involve conduct that is misleading or deceptive or is likely to mislead or deceive* (ACCC/HCCC, 1999, p, 3). Consideration of this issue resulted in the following comments by the Committee of the NSW Inquiry into Cosmetic Surgery (1999), with regard to evidence that the promotion of cosmetic surgery has made extensive use of the same sorts of body imagery that are standard practice in the cosmetics and beauty industries:

> *All the health complaints bodies noted that promotion of cosmetic surgery is having an impact on consumer expectations about what can be achieved.*
>
> *A number of practices in advertising, media and information services about cosmetic surgery may be in breach of professional standards and fair trading laws. They include:*
>
> *- use of models, implying the model has had the procedure or that the procedure can achieve the results (with or without a disclaimer);*
>
> *- 'before and after' photos that have been enhanced, or are different in size, colour or pose, or give a misleading impression of long-term effects of a treatment;*
>
> [together with a number of other items relating to promotional text (Committee of Inquiry 1999, p. 59)]

The Committee of Inquiry (1999) also noted that few complaints had been received from consumers, *about advertising and promotion that breach fair trading laws* (p, 59). In a recent draft guide to the Trade Practices Act for health workers, it was pointed out that not only consumers can take legal action, but that the Australian Competition and Consumer Commission (ACCC) can also institute proceedings for a court to decide whether there has been *a breach of the Act* (ACCC/HCCC, 1999, p, 31).

Acceptable practice or litigiously misleading and deceptive?

Quite apart from any possible impact of using ideal bodies, artificially enhanced, as a promotional device to sell goods and services that have nothing to do with the body, there is the question of the legality of using unrealistic images to 'demonstrate' the benefits of products and services for the body itself. This has, by and large, been taken for granted as part of the acceptable hype that characterises advertising. Have we, however, reached the point at which the ideal images used in the mass media have crossed the boundary between what is acceptable and self-evident, to what is legally misleading and deceptive? And, if that is the case, is it a matter for individual consumers, or for an arm of government, to challenge these practices in the court?

Are ideal body images a health hazard?

The answers to this question could be influenced by the extent to which the use of misleading and deceptive images is considered to have a negative impact on health. As indicated earlier, there is a growing body of evidence that identifies ideal body images as a health hazard. These images have been shown to impact on body image problems, including eating disorders and other conditions, ranging from the mild but pervasive to the severe but less common pathologies. These are more prevalent in females, but are increasing in males.

Concern about these conditions has motivated the publication of this book, and given rise to a variety of counter-measures and proposals to manage, treat and prevent body image problems. As exemplified in the proceedings of the 1997 conference 'Challenge the Body Culture' (Gaskill & Sanders, 1998), these activities range from the micro-level, directed at the individual, to macro-level social interventions, and include strategies such as counselling, education, self-help publications, health promotion, social action and media advocacy.

Concluding caveats

There is now a substantial body of literature reporting on the trialing of, and other research into, a variety of such counter-measures (eg Gaskill & Sanders, 1998; Rabak-Wagener, Eikhoff-Shemek & Kelly-Vance, 1998). There is also reporting of educational strategies that go beyond body image issues to deconstruct the broader tactics of persuasion that are strategies fundamental to advertising (eg McCaleb, 1977). It is not within the scope of this Chapter to comment on these initiatives. Instead, attention is drawn to some of the contextual factors that need to be taken into account with regard to current media trends promoting the dissemination of unreal and enhanced body images.

Are social pressures to look good, a fertile base for the body business?

There has been a considerable emphasis, in this Chapter, on the role of advertising in creating a need. At the same time, however, it is important to be aware that the body business can also be seen as responding to a contemporary need that is based on the extent to which *bodies are central to individuals' modern lives* (Stewart, Eckermann & Riggs, 1998, p, 140). To some extent, the visual emphasis on perfect or considerably better bodies could be seen as a response to the recognition that a good appearance is increasingly regarded as an important resource by both sexes. How important a resource it should be, and the extent to which this remains a gender issue, are questions which need to be addressed at *the macro level of social relations* (Stewart, Eckermann & Riggs, 1998, p, 140).

Is the control of covert practices a feasible or a futile exercise?

As to the more specific issue of a social response to the use of ideal body images as a pervasive marketing device, there are some very practical considerations limiting the feasibility of effective action if the aim is to keep the use of such imagery within the bounds of reality. In terms of effective controls, the complexity and covertness of many of the financial arrangements and less clearly articulated spheres of influence between advertisers and the media means that any self-regulatory or even legislative action would be difficult to implement and monitor without the imposition of strict accountability guidelines.

Could media advocacy be a really effective weapon against unreal body images?

In terms of the body-image-in-advertising issue, it would be similarly challenging to implement broader social action measures. The conventional approaches to media advocacy, such as have been outlined by Chapman & Lupton (1994) in the highly relevant context of public health, would have a particularly hard row to hoe in this regard. This is due to the fact that the harnessing *of the news media is absolutely central to the conduct of public health advocacy* in its task of overcoming structural rather than individual barriers to particular public health goals (Chapman, 1994, pp, 17-18). The reason behind this is that the cost of purchasing sufficient advertising time to inform and persuade decision makers or the public about the need for change is too expensive. And typically, even though such advocacy faces some of the most formidable political, economic and cultural forces imaginable, some access to what is, in essence, free publicity and promotion is feasible. This is because individual public health goals are generally specific enough for each one to be picked up by at least some mass media outlets which do not have a conflict of interest about the particular issue (Chapman, 1994).

Much of this Chapter has focussed on both the reasons for the pervasiveness of unreal body images, and the intricate inter-relationships between advertisers and all sectors of the commercial media which help to perpetuate those images. These relationships put editorial independence at risk by posing conflicts of interest. This must raise substantial doubts about how realistic it is to be able to make effective use of the non-advertising sector of the media as an agent of advocacy for change in this area.

At the same time, it is important to recognise that various types of mass media do periodically feature body image issues as a target of editorial concern. This highlights some of the additional complexities that need to be taken into account when considering the potential value of using the media to change the media. The most recent illustration of some of the inherent difficulties comes from the aftermath of the Australian Broadcasting Authority's (or ABA's) 'cash-for-comment' hearing. The continuing success of the 'unrepentant broadcasters' at the heart of that case, who have retained a substantial proportion of their listeners and advertising clients, flies in the face of a 'media blitz' described as the biggest since the Lindy Chamberlain affair (Adams, 2000). This gave extensive coverage to the ABA's condemnation of these broadcasters' activities, and its imposition of a number of regulatory conditions (Adams, 2000; Williams, 2000).

In the light of outcomes such as this, some media commentators consider that in the current climate, the solution lies more directly with the audience (eg Adams, 2000; Williams, 2000). It is, they suggest, *we the consumers* [who] *are the only ones with the power to have any meaningful impact*, by *switching off in droves* (Williams, 2000, p, 35), and that, finally, the responsibility lies with *the "us" who declined to turn the dial or the page* (Adams, 2000, p, 32). From their perspective, the bottom line may well be that the most effective agent for changing the media is direct action by its consumer base. Is this what is lacking with regard to the use of unreal body images by and in the media? Certainly, all the concerns raised about this to date have not provided sufficient incentive for the media or their advertisers to change, beyond the tokenistic ways described earlier. Is this because enough people continue to watch and read the media that contain those images, and to buy the products that they are used to promote?

This leads to the question of whether there is, in fact, a critical mass of people who believe that there is a need for change. And, ultimately, so what if there is? That last, and perhaps most challenging, question reflects the concern raised by health historian Elizabeth Haiken (1997). *Given the complexity of the modern world*, her fear is that as individuals we have *lost faith in the possibility that commitment and collective action can transform the society in which we live* (p. 15), and, instead, have come to believe that the easiest way of tackling social problems is to change the self.

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Chapter 6 – The Media's Role in the Psychopatholgy of the Eating Disorders

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Glenn Waller

There has long been a widespread belief that the media's representation of the 'ideal' female body is partly responsible for the prevalence of eating disturbance. This attitude is particularly strong in those countries where the ideal female form is portrayed as very slender. Unfortunately, it is a belief about causality that is based on comparatively little evidence. Indeed, magazine editors have claimed that all they are doing is reflecting existing preferences within society – if people want to see skinny models, then who are they to stand in the way of what people want? How could we interpret such philanthropy as having a negative effect upon the readers?

Briefly, the causal arguments that have been made over the years are far from simple. My own interest in this field started as do many of my interests, with a clinical question where I was unable to come up with a simple answer. I tend to find that my anorexic and bulimic clients know a lot of the important questions (and answers), and I just need to focus on listening. A couple of the clients who I was seeing told me how they hated reading fashion magazines, because they made them feel so inadequate. Indeed, the topic first came up when one of these women came into my office angry, having become very worked up while reading such a magazine in the waiting room. With my 'scientist' hat on, it seemed to me that one could easily look at the clinical effects of such publications within an experimental framework. I discussed this idea with a colleague, who was pregnant at the time. Her understanding was very helpful – she felt unable to look at her copy of Vogue as she grew larger. That point helped me to understand that the phenomena that I was considering were not about abnormality, but about the reactions of normal individuals under particular conditions. From this rather simplistic idea, a rather pleasing little line of research developed. With the assistance of some very good students (particularly Kate Hamilton, Julie Shaw and Alexandra Sumner), I carried out some of the earliest experimental studies into the impact of the media upon body and self-image.

The findings (some of which are outlined below) were very pleasing, although far from surprising. Having done those studies, I felt that the basic question had been asked and answered. Since I do not believe in researching an area to death (much more satisfying to keep one's work at least vaguely clinically relevant), I then moved on to investigating other areas of eating disorders. What I had not anticipated was that the research would be so popular with the media themselves. When the results started to come out, I entered a couple of months that could best be described as 'hell on earth' – it seemed that every newspaper, radio show and television channel wanted to get an interview. Oddly enough, most of them were even fairly accurate. The one part of the media that did not seem keen to get my perspective was – surprise, surprise – the fashion magazines. However, I did have the chance to argue on-air with the editors of British Vogue (used strategy 1 – 'this may be accurate but it is all old hat, we no longer use thin models') and Cosmopolitan (used strategy 2 – 'how could you suspect us of doing such things, these poor anorexics need all our sympathy for choosing such a way of life'). An edifying experience. My intention here is to introduce you briefly to the evidence base that we have generated, and what it tells us about the media's influence on eating psychopathology. Having done that, I will consider the psychological models that we might use to explain why these effects take place, since such models are useful in planning and executing treatments. I will then go on to think about the media's use of photographs and their agenda, before discussing what might be done.

The evidence base

When I started in this area, there were two principal difficulties in interpreting the existing evidence about media effects. First, the existing findings had no clear theoretical base, meaning that it was difficult to make them relevant to any coherent model of treatment. Second, the studies were largely correlational, which meant that one could not draw any clear conclusions about whether the link was truly causal in the assumed direction (the media's portrayal leading to eating problems in society). Therefore, we decided to use an experimental method, and devised a simple paradigm to help us decide whether the use of photographs of models from fashion magazines could influence women's body and self-image (see Waller, Hamilton & Shaw, 1992). Hamilton & Waller (1993) showed that anorexics and bulimics overestimate their body size more after viewing these magazine images. This effect was not present in the group of comparison women as a whole, but Waller, Hamilton & Shaw (1992) showed that the effect was present for non-eating-disordered women who had more unhealthy restrictive eating attitudes. Further work that we have done has shown that there are similar effects of such media images in other groups, including adolescents and pregnant women (Sumner, Waller, Killick & Elstein, 1993). The experimental nature of these studies and their use of real-life fashion images gives strong support to the suggestion that the media play a direct causal role as one of the factors that interact in the development of eating problems. In particular, it seems that one finds these effects most readily among women who already have reasons to focus on the shape of their bodies (where they have eating disorders, are pregnant, or are experiencing the bodily changes associated with pregnancy). Since these studies were conducted, a number of other studies have been carried out, and the results have broadly supported these initial findings. It seems safe to conclude that we now have a sufficient evidence base to conclude that the media's portrayal of the 'ideal' female form as skinny is a pathological influence among those women who already have some of the setting conditions for eating disturbance. In other words, the media's influence can only be understood within a multifactorial model of the aetiology of the eating disorders – but it undoubtedly has a role to play.

Psychological models

Media influences on identity formation, body image concerns and eating problems in women are probably best explained by theoretical perspectives drawn from the field of social psychology. Three such theories suggest themselves, although each is better understood if it is considered within the broader frameworks afforded by multifactorial, sociocultural and feminist theories. Social identity theory suggests that self-image is made up of both a personal identity and a social identity. The social identity comes from identification with one or more social groups. A more positive social identity is associated with the increasing social desirability of the group of which one is a member. Where the media present images that promise or imply social acceptance for thin females (i.e., only thin women get to be important enough to be models), this body type is made highly desirable. Social learning theory focuses on the powerful influence of role models on the development of gender-related self-identity during childhood and adolescence. Bandura (1977) concluded that the most effective role models are those who the individual perceives as most similar to themselves. The media present role models which adolescent girls are readily able to use in their search for self-identity. Such media images are appealing because they offer a focus for adolescent anxieties concerning the dramatic bodily changes during puberty. The mass media present an ideal body type for women, and image-sensitive adolescent girls experience pressure to conform to that ideal.

Social comparison theory (Festinger, 1954) suggests that there is a need to use others as a source of information about social phenomena in order to evaluate one's own abilities, attitudes and other characteristics. Thus, social comparison theory might explain how women use media images as a reference source in evaluating their own body image. The media's ubiquitous use of thinness as the ideal standard of bodily attractiveness for women (Silverstein, Perdue, Peterson & Kelly, 1986; Andersen & DiDomenico, 1992) is likely to cause dissatisfaction and anxiety in the large number of women whose bodies do not match this ideal. These theories are not gender-specific, so why are women's eating attitudes particularly likely to be affected by the media? The answer is probably two-fold.

First, the media stress the value of bodily control far more for women than for men (Silverstein et al. 1986; Andersen & DiDomenico, 1992). Therefore, women are more likely to be dissatisfied with their 'imperfect' bodies and to seek social and personal acceptability by striving to achieve this 'ideal' goal of bodily control. Second, women are afforded fewer means of control over their own lives than men in most societies. Men who experience the same initial antecedents as women (including media pressures towards bodily control) may be able to establish control over other aspects of their own lives (for example, at work) in ways that are less likely to be available to women.

The camera never lies?

An argument that is sometimes raised is that the media simply use pictures of normal women (albeit thin ones), and that if one is offended or influenced by such portrayal then one should expect similar effects from everyday life. Of course, such an argument depends on the proposal that the media use pictures of real women – after all, the camera never lies, does it? This is where the whole case tends to collapse. The camera does not lie, but it can be made a tool for forgers, particularly in the age of the computer. It is easy to find examples of photographs in magazines and newspapers where one can clearly see that parts of the body have been 'shaved' or airbrushed out of the picture. In many cases, the quality of the forgery is very poor, and can be easily spotted with very simple scrutiny. The editors do not even have the decency to cover their tracks. A recent example came when a British national newspaper made radical changes to a picture of the Princess of Wales and Dodi Fayad, just weeks before their deaths. The two were moved together and his head was swivelled to face hers, to give the appearance of a couple about to kiss. The photo was headed something like: 'The picture they (the other newspapers) all wanted'. True, everybody seemed to want a picture of this couple kissing, and since it was a computer-assisted forgery, no other paper was likely to have the picture. But just remember that story when you next hear that the camera never lies.

The media's agenda

There is a clear agenda for sufferers and clinicians alike – how to get the media to act in a more responsible manner. Before asking what one might do to address this problem, it is important to consider the media's own agenda, in order to determine whether our efforts will be useful. First, remember the profit motive. The media are not there as a charity. In order to make a profit, they must gain a captive audience, create an image for the readers to crave, and create a perceived need for their product (among both readers and advertisers). And don't worry if you are not sufficiently skinny or curvaceous – there are all those advertisements for cosmetic surgery and liposuction towards the back page. None of these needs are compatible with a socially responsible attitude. Second, the media need to create a corporate image, which involves ensuring that you realise that you are not sufficiently attractive unless you are good-looking (the perfect body and the right clothes). Thus, one is left with the desire to achieve this picture of perfection, due to the psychological processes outlined above. However, while the media will happily provide the definitions of acceptability, remember that they will also change the definitions on a seasonal basis. After all, it would not do to let anyone get happy with the way they are – it is hardly good for sales. Finally, remember that the media get a large proportion of their income from advertising – often more than they attract from sales. The media's symbiotic relationship with advertisers must be understood. Would anybody buy some of the goods that some manufacturers produce if it were not for their presentation as desirable in the 'authoritative' magazines? And how would designers get their publicity if the magazines did not cover the launches at fashion shows? So consider whose interests are at the forefront of the minds of those in the media. Whoever it is, it is not the reader.

Conclusions

Both psychological theories and research evidence show that the media can influence the development and maintenance of eating problems in some women. It is facile to argue either that one does not have to look at the images (how can one avoid such portrayal of the 'perfect' form, without going around wearing a blindfold) or that the ideal image is changing over time (as long as there is an ideal, the vast majority of women will fail to achieve it, and hence will be dissatisfied). There is little evidence that prevention programmes have any effect, and they may even be harmful. One could argue that there should be a moral agenda for the media, stressing its need to be responsible. However, the same case could be made about the tobacco and alcohol vendors – the pathological effects of their products are much better established in the public and medical arenas but there is still no clear pattern of ethical behaviour within those industries. In brief, the media are likely to be more responsible only under one of three conditions: a sharp intake of morality, potential profit, or legislation. It is only the last of these that seems possible.

So what should be done? First, we need more evidence about whether it is possible for prevention programs to reduce the pathological influence of the media's portrayal of women. Second, it would be valuable if the media were to use a broader range of models, so that no one body shape is presented as ideal, but all shapes are seen as acceptable. Will the media accept such a change as part of a voluntary code of practice? 'No' seems to be the only sane answer to that question. The alternative would seem to be the route of imposing legislation to prohibit the use of such pathological images. Surely, it would take a mad person to call for such a course of action. However, I think that the situation is mad enough to require that I should suggest that we should be going down just that road.

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Chapter 7 – Barbie Magazine: The First Twelve Months

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Fran Sanders, Elizabeth Gwynne and Deanne Gaskill

Recent research has demonstrated the impact of media images on the self-esteem and body satisfaction of adolescent girls and young women (Gwynne, 1997; Heinberg, Thompson & Stormer, 1995; Tiggemann & Pickering, 1996), and the concerns of children as young as six years with their size and appearance (Collins, 1991; Veron-Guidry & Williamson, 1996). In July 1996 *Barbie*, a monthly magazine for girls, hit the Australian news stands and achieved instant popularity. The magazine presents an enormous array of product information, give-aways, fashion, readers contributions, TV and other personalities, competitions, and of course Barbie herself as mistress of ceremonies.

It has been argued that childrens' play is a major contributor to their socialisation and that toys which represent the body (for example, dolls) influence the ways in which they relate to their own bodies (Norton, Olds, Olive and Dank (1996). In this context, analysis of the Barbie doll phenomenon has criticised the inappropriateness of the narrow and unrealistic stereotypes presented (Norton et al. 1996). *Barbie* the magazine further develops and reinforces the images the doll has already established and moves girls into overt consideration of fashion and beauty directly related to them and their age group.

In the latter decades of the twentieth century Western society has developed an obsession with body size and shape. Slenderness is revered, especially in women. Throughout history, appearance and beauty have been the central characteristics of the female gender role with attractive women being considered more feminine. A woman's status has been largely determined by physical appearance whereas a man's status has been more frequently dependent on his physical and intellectual prowess (Lerner, Orlos & Knapp, 1976). Given that thinness represents Western societies current ideal of beauty and femininity, *the pursuit of thinness by females can be understood as both culturally bound and as incorporated in the female stereotype* (Nagel & Jones, 1992, p. 109).

The media is generally seen to have a major influence on perceptions of beauty (Martin, 1989), and commercial magazines are a significant source of media influence (Evans, Rutberg, Sather & Turner, 1991). It must be remembered that advertising provides the primary source of revenue for commercial magazines (Evans et al. 1991) and that economic concerns play a central role in determining content and presentation. Children are now recognised as a group with significant spending power, and have therefore become consumers in their own right (Pecora, 1995). Increasingly, products are being created for children as a consumer group and advertising being directed specifically at them.

The media has also been identified as a major source of knowledge and socialisation for children, with 90% of teenagers in one study reported as gaining their knowledge of the world through various media sources (McCaughan, 1994). The marketing literature reveals that targeting children in advertising is seen as legitimate, and that serious research goes into identifying how to do this most effectively (Macklin, 1990). Further, it seems that children are particularly vulnerable to advertising messages, and have difficulty in discriminating between content and advertising presented in the media (Kunkel & Roberts, 1991).

Authors of research into teen magazines comment on their influence on young women's gender role choices and the narrowness of images presented. Generally such publications tend to reinforce stereotyped and traditional roles and power relationships (Finders, 1996; Christian-Smith, 1993; Evans et al. 1991).

The aim of the current study was to conduct a content analysis of the first twelve issues of the Australian version of *Barbie* magazine in terms of the quantity, nature and content of messages conveyed to readers, the use of advertising, and sex role stereotyping. In the current paper the authors present a discussion of the central issues and challenge the magazine in relation to its approach to advertising and its perpetuation of traditional sex role images.

A content analysis process based on Weber (1990) was used. Four major categories were identified: advertising, entertainment, information and reader involvement. Each of these was further divided into a number of sub categories. Through these categories, the issues of presentation, intent, content type and sex role stereotyping were analysed.

Barbie magazine is targeted at pre-pubescent girls aged six to twelve years, and is the first publication to appear in Australia that could be argued to be a childrens' version of adult women's magazines. It is colourful, uses lots of pastels, particularly pinks, and provides material that is varied and attractive to young girls. It links into the developmental stage of the target audience, and addresses issues of importance to girls. For instance, there are features on sisters, mothers and daughters, pets, dressing up, TV stars, Barbie dolls in numerous guises, and the environment in a 'feel good' way. Regular features, many of which are linked directly to Barbie and Barbie products, include beauty and fashion, a 'Dear Barbie' column, a pull-out Barbie poster, competitions, fiction (always a story about the adventures of Barbie and her friends), reader profiles, 'when I grow up' and give-aways. High reader involvement is a prominent feature with a range of letters, photos, drawings, poems, stories and features appearing in every issue.

Advertising

Advertising is blended into content throughout the magazine. For example, in a typical issue, such as Number 9 (April '97) there are 56 pages plus inside and outside covers. Of these, fifteen pages contained adverts for Barbie dolls, the magazine, or other products; sixteen mentioned Barbie, offered Barbie prizes or giveaways, or included readers drawings or photos featuring Barbie; twenty-one pages advertised other products, and a shopping guide is included at the end of the magazine. Even the contents page carried pictures of identifiable products. Only six pages were advert free. Fifteen pages carried full page advertisements for a single company or product, and a further eight pages were full page adverts for an assortment of products. In addition, the seven pages presenting the fashion feature were in effect full page advertisements, as prices and purchasing information on all clothes displayed were included. Readers were used as models in this feature. This same basic format is used in all issues.

The few pages in any issue that could be seen to provide information apart from product information, are often linked with a product at the end. For example, in issue 8 (March '97) pages 46 and 47 give interesting information on flowers. However, also included, is an advert for Flower Fun Barbie posing as part of the feature, and an offer to win a book, *Flower Faries – The Meaning of Flowers*. How many children who miss out on winning one of the giveaways, pressure their parents to buy them the book? Or begin to demand, beg, cajole for a Flower Fun Barbie? In such ways, advertising is subtly included throughout the magazine.

The fiction section 'Story Time' in every issue provides an extract from a Barbie book purchasable through a number of stores. Each ends with the advice 'To find out what happens....you can get the book at...'

The clear message throughout the magazine is that to have fun, to be 'cool', to be happy, to be part of the group, a girl needs products, products, products.

The images conveyed

Mitchell and Reid-Walsh (1995) describe Barbie as a cultural icon, standing for beauty, the male gaze, the body, materialism, fashion, femininity, big business and mass marketing. Enormous commercial enterprise surrounds Barbie with collector's cards, games, clothes, books, animated aerobics videos, eating utensils, look-alike competitions for adults, and of course the huge range of Barbie dolls and accessories. The presence and image of Barbie is all pervasive, and new products are being created daily. The unrealistic proportions of the Barbie and Ken dolls have been analysed in the literature (for example, Norton et al. 1996).

In the magazine, traditional roles and images of women and girls are presented and reinforced. The colours used are soft and bright pastels, with pink predominating. There is an overwhelming emphasis on beauty, clothes, and being pretty, and the products which supposedly enable this to happen. With few exceptions photographs show attractive, fair haired girls with Anglo-Saxon appearance. A number of features present girls dressed up – as fairies, mermaids, ballerinas, princesses, or in pretty, pastel and stereotyped feminine clothes. There are no girls dressed up as an engineer or working as a mathematician!

Overall, the magazine conveys limited aspirations to readers, and fails to present any challenges – except perhaps how many products a reader can convince her parents to buy for her! For the most part the activities portrayed are of very traditional feminine roles and interests.

Most issues include a 'Story Time' segment which presents the adventures of Barbie and her friends and in which Barbie is always the central character. These stories typify the stereotyped role models for which the whole Barbie concept has been criticised. The story Butterfly Island in Issue number 2, August 1996, is an example. The story is about Barbie assisting a friend Kara to develop her own designer label for a fashion competition. Barbie noticed the *wistful expression* of a young girl Annie Rose who she sees *with her outstretched hand reaching for a garment* [and] *stroking the material* and *with her face pressed up against the glass spellbound*. Annie Rose is described as being *very pretty with honey-coloured hair and large hazel eyes...Barbie thought that this attractive young girl could become a successful model*. In these stories too, clothes are frequently described: *Barbie was wearing a white cotton dress with gold buttons that glinted in the sunlight. She wore matching gold earrings and her long blond hair was tied back with a gold scarf...*[she] *wore pretty white sandals on* [her] *feet*. Stereotyped and 'ultra feminine' behaviour, appearance, activities and interests are continually reinforced.

In many areas of the magazine including stories, fashion, entertainment and information provision, fiction and reality are blended. Examples include Barbie on holiday in the United States and pictured at popular tourist sites (Number 7 '97); Barbie featured on Bay Watch dressed in the same costume as Pamela Anderson (Number 8 March '97); and in Number 3 (September '97) where Barbie is pictured wearing outfits identical to those of famous designers. In this way, the Barbie of the magazine can become very real to young girls – far more real than the doll they can hold and manipulate – and therefore the influence of the identity and role conveyed is likely to be considerably greater.

What, then, is the purpose of the publishers in producing this magazine? It is difficult to reach any conclusion other than that each issue is a large and clever advertisement which uses developmental and psychological knowledge to market products to young and vulnerable children. Certainly it entertains, but that entertainment value is based upon the purchase of a whole range of products. The ethics of targeting product marketing at children must be questioned, and the ways in which it is done debated. Resisting the influences of marketers when their messages pervade children's play, interaction with their peers, and normal growth and development, is extremely difficult. To argue that people have a choice about what they buy is simplistic and often unrealistic. For those who wish to see children, and particularly girls, raised with a sense of themselves and their potential in the world unrelated to what they look like, publications such as *Barbie* magazine must be of enormous concern.

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Chapter 8 – Cosmetic Surgery and the Body as work-in-progress

Anne Ring

Introduction: the new face of cosmetic surgery

The 1990s heralded a dramatic shift in attitude towards cosmetic surgery in Australia, from what was previously seen as a socially unacceptable vanity to one of the most popular strategies to achieve and maintain an acceptable appearance (Ring, 1998). The power of this strategy was its access to a level of medical technology with the capacity to effect remedial work on the appearance of virtually any part of the body (Haiken, 1997; George & Dickens 1998, 1999). This now complements the other methods of dealing with body dissatisfaction, namely diet and exercise to change weight and shape; garments to disguise and modify shape; and cosmetic and body care products for skin and hair. Each of these cosmetic interventions is the basis of a vast industry whose profits depend on promoting body dissatisfaction. It is interesting to examine the relative values of each of these components as reported in the USA in the early 1990s (McGrath, 1994). The figures in Table 1 show both the magnitude of the economics involved and illustrate just how successful an industry cosmetic surgery has become.

Table 1: The Body business in the USA

The business	The profits
Cosmetics and Toiletry industry	$18.5 billion
Diet industry	$33 billion
Fashion apparel industry	$181 billion
Cosmetic surgery industry	$300 billion

(Figures from 1990-92, in McGrath 1994, p.230)

The relevance of these figures to the Australian context, in proportionate rather than absolute terms, is high because comparison between the current status of cosmetic surgery in Australia and that in the USA over the past two decades shows some very close parallels. What until recently had been described as *the peculiarly American phenomenon* of cosmetic surgery (Haiken, 1997, p. 288) can be seen to have spread to Australia with all the characteristics of status, prevalence, methods of promotion, and its comparatively unregulated practice (Ring, 1999a, 1999b). In both countries the most popular cosmetic surgical procedure is liposuction (Harkness, 1994; Committee of Inquiry, 1999). This is the medical weapon that has now joined dieting and exercise in the constant battle against dissatisfaction with bodies, primarily, overweight and out of shape.

What counts as cosmetic surgery?

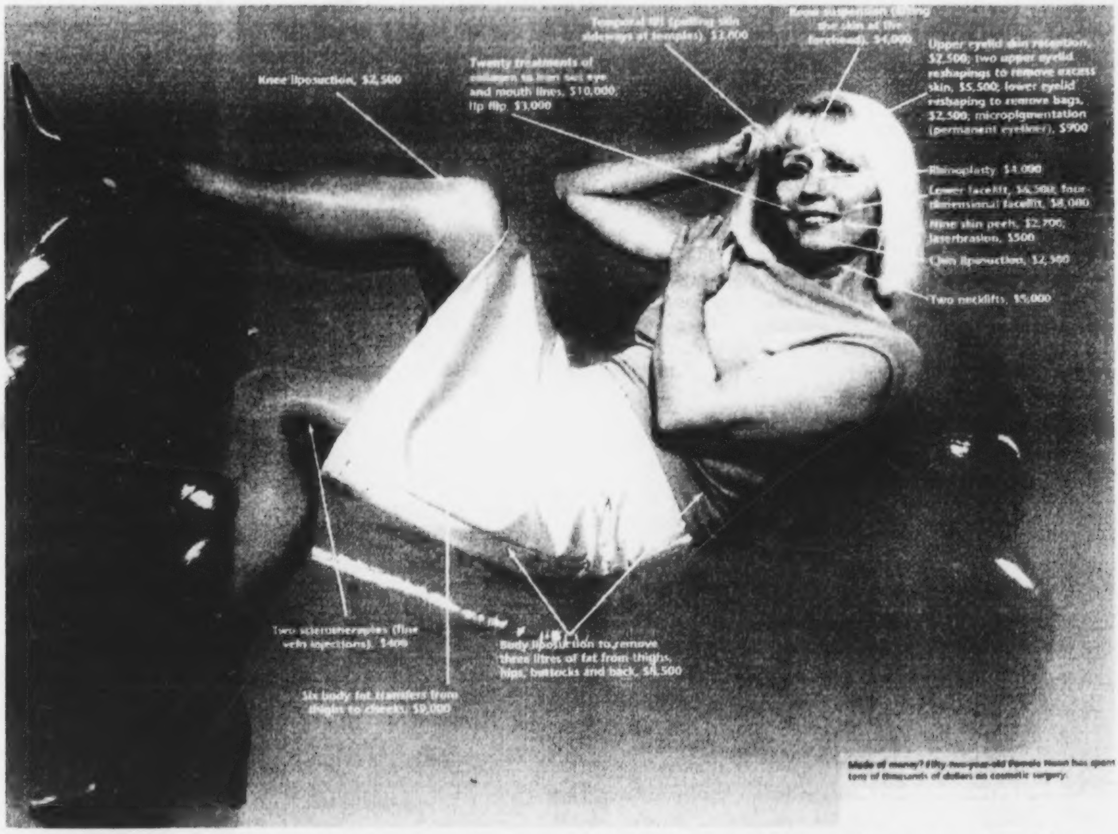
The increase in publications about cosmetic surgery shows that this phrase now encompasses far more than would be expected from a literal definition of the terms involved. In everyday English, 'surgery' is understood to be the specialist practice of operating on the body of a patient who is under a local or a general anaesthetic, and within a hospital or day clinic. It is seen as being a major medical procedure, invading the body and having a set of potential risks and iatrogenic consequences. Currently, however, cosmetic surgery is by no means restricted to surgery of that order. Instead, it has come to serve as an umbrella term for a range of procedures that includes the full spectrum of interventions, from non-invasive to seriously invasive, as long as they are carried out on a patient by a registered medical practitioner *solely for reasons of appearance* (Haiken, 1997, p. 5). Because of varying expectations about what is included, as well as some inherently confusing aspects of the way the term is used, the recently completed NSW Inquiry defined cosmetic surgery as follows:

> ***The scope of cosmetic surgery:*** *Cosmetic surgery is a procedure performed to reshape normal structures of the body, or to adorn parts of the body, with the aim of improving the consumer's appearance and self-esteem....The Committee notes that 'improvement' of appearance is a subjective one, defined by the consumer and that cosmetic surgery:*
>
> - *is initiated by the consumer, not medical need;*
> - *includes any cosmetic treatment, including cosmetic surgery, cosmetic injections, or other cosmetic procedures;*
> - *excludes reconstructive surgery...[which] is generally performed to improve functions, but may also be done to approximate a normal appearance (Committee of Inquiry into Cosmetic Surgery, 1999, p. 1).*

As shown by the following list of procedures and the accompanying illustration, no part of the body needs to be left 'unnipped' or 'untucked'. Bodies can also be *lasered, sculptured, sucked out, implanted, injected and lifted* (Ring, cited in Gare, 1999, p. 10), as well as having hair removed or added.

Cosmetic surgery procedures most commonly practiced in Australia are listed below, some with the approximate cost:

Abdomenoplasty - tummy tuck: $3,500 - $5,000
Blepharoplasty - eyelid surgery: $1,200 - $3,000
Botox therapy - forehead-paralysing toxin injection
Breast augmentation: $3000*
Breast reduction: $3,500*


Knee liposuction, $2,500
Twenty treatments of collagen to iron out eye and mouth lines, $10,000; lip flip, $3,000
Upper eyelid skin retention, $2,500; two upper eyelid reshapings to remove excess skin, $5,500; lower eyelid reshaping to remove bags, $2,500; micropigmentation (permanent eyeliner), $900
Rhinoplasty, $4,000
Lower facelift, $6,500; four-dimensional facelift, $8,000
Nine skin peels, $2,700; laserbrasion, $500
Chin liposuction, $2,500
Two necklifts, $5,000
Two sclerotherapies (fine vein injections), $400
Body liposuction to remove three litres of fat from thighs, hips, buttocks and back, $8,500
Six body fat transfers from thighs to cheeks, $9,000

Pamela Noon, 52, as the epitome of the body as work in progress, with 'a startling total of 54 cosmetic surgery procedures' since the age of 38 (Hawley, 1999, p.16). Reproduced with permission from The Sydney Morning Herald Magazine Good Weekend (June 5, 1999, pp 16-17), with photograph by Tim Bauer

Brow lift: $1500 – $4,500
Chemical peel: $600⁺ per region
Collagen/fat injection: $200 – $460
Dermabrasion: $600 per region
Facelifts
Facial implants
Hair replacement surgery
Hair removal by lasers
Laser resurfacing: $800⁺ per region
Liposuction: $500 – $5,000
Otoplasty-ear surgery: $500 – $5,000
Penile enlargement: $14,000
Rhinoplasty-nose surgery: $1,500⁺
Sclerotherapy – vein treatment

Compiled from: Committee of Inquiry (1999, pp.ix-x); *Cosmetic Surgery Magazine* Issue 2 (1999, pp. 8-9, 40); Short, in *The Art of Cosmetic Beauty*, Volume 3 (1999, p. 67).

Implications of policy for the practice of cosmetic surgery

In conjunction with advances in medical technology that make so much of the body amenable to changed appearance, there have been some important developments in the practice of, and payment for, cosmetic surgery. Originally, cosmetic surgery was regarded as being primarily in the province of plastic surgeons and was more generally known as plastic surgery. This was an accepted and rebateable area of specialist medical practice within Australia. With an increased range of procedures and types of medical practitioners performing them, their position on the Medicare rebate list was reviewed, and eligibility for rebate came to depend more on the reason for having surgery. By 1981, several procedures were no longer covered by Medicare when carried out solely for the sake of appearance, reflecting the view that they were considered to be unnecessary for healthy individuals whose bodies were within the normal range of appearance (Alderton, 1981). Some other procedures such as rhinoplasty, breast reconstruction and reduction, and varicose vein removal, remained on the list, on the basis that they had some 'reconstructive or therapeutic' component (Committee of Inquiry, 1999, p. 8).

While technically, plastic surgery encompasses both reconstructive and cosmetic surgery, 'true' plastic surgery is coming to be associated more restrictively with the specialised targeting of *malformed or damaged* parts of the body (Macquarie 1998, p. 1643), and is *generally performed to improve functions, but may also be done to approximate a normal appearance* (Committee of Inquiry, 1999, p. 1). Currently, rather than being synonyms, for practical

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purposes cosmetic surgery and plastic surgery can be regarded as referring to two different aspects of practice. That distinction is maintained in this Chapter, and is critical because the user-pays-for-almost-all-procedures policy in cosmetic surgery, but not in plastic surgery, has had far-reaching consequences in terms of who provides cosmetic surgery, and who accesses their services.

Who does it?

Training and qualifications – not essential

The current practice of cosmetic surgery has highlighted (to a generally unaware public) that *any registered doctor can call themselves a surgeon* in Australia (Committee of Inquiry, 1999, p.21) and this can be from the moment that they have satisfactorily completed their intern training. Any doctor is legally entitled to perform any medical procedure in this country, no matter how complex, even if it is conventionally carried out by doctors with appropriate specialist qualifications (Ring, 1998; Committee of Inquiry, 1999). Moreover, the usual economic, rebate-linked constraints on the practice of particular procedures do not apply. This is because *cosmetic surgery is not covered by Medicare…there is no requirement to be referred by a GP, and no [associated] Health Insurance Commission accreditation* (Committee of Inquiry, 1999, p. 21).

For cosmetic surgery, where both the demand for services and the fees for those services are high, the lack of constraints on practice has contributed to it becoming *the fastest growing* sector of medical practice (Spowart & Mastrantone, 1999, p. 23). Plastic surgeons who practice cosmetic surgery (and who sometimes call themselves 'cosmetic plastic surgeons') have been joined by doctors from every other medical discipline, some of whom have only the most basic qualifications for medical practice. While plastic surgeons consider that they form a distinctive group signalled by the label of their specialty, average consumers tend to perceive all doctors who perform cosmetic surgery as 'cosmetic surgeons', and this label of convenience is used throughout this Chapter.

Within this wider group of practitioners, considerable tension exists between plastic surgeons and other cosmetic surgeons. In some quarters this is seen as due to differences of opinion about suitable training. With the formation of a new college of cosmetic surgery (membership of which is not compulsory), there is also a view that at least part of the tension can be ascribed to what has been called a 'turf war' over this lucrative area of medicine (NSW HCCC, 1999).

These and related issues regarding who does, and who should, practise cosmetic surgery, are important to illustrate the disarray that exists within a sector of the medical profession over activities that have significant implications for the physical and psychological well being of patients. Concerns about this situation were among the key factors that led to the establishment of the recently completed Inquiry into Cosmetic Surgery in NSW, and were the focus of two of its terms of reference:

- to identify and review the adequacy and limitations of existing consumer safeguards including those relating to regulatory and professional registration processes;
- to make recommendations to the Minister for Health on the need for and options for additional safeguards for consumers (Committee of Inquiry, 1999, p. 1).

Ethics and the 'retail end of medicine'

Apart from problems arising from lack of consistency and difficulty in enforcing training for cosmetic surgeons, the issue of the well being of patients has also been raised from the point of view of the essentially different nature of cosmetic from other areas of medicine, because it is targeting people who are already well, as potential consumers of the services offered. These consumers are, therefore, taking on the associated health risks of surgical intervention for what could be considered superficial reasons.

It has been suggested, in both the American and Australian contexts, that this need to market medical services to healthy people has posed an ethical dilemma for doctors, and that there have already been some disturbing consequences (Wolf, 1990; Spowart & Mastrantone, 1999). The author of *The Beauty Myth*, for example, considered that in the absence of a *naturally replenished…patient pool of the sick and dying*, cosmetic surgeons have to create a market of healthy clients, by exploiting women's insecurities about their appearance. This market creation strategy *seems not to be subject to the ethics of the genuine medical profession* (Wolf, 1990, p. 234).

One approach to resolving this dilemma was summarised recently by a cosmetic surgeon who contributed to the NSW Inquiry into Cosmetic Surgery. Essentially, it involves reconstructing this sector of medical practice in more explicitly commercial terms:

> *You have to recognise that cosmetic surgery is the nearest thing you're going to get to retail medicine – or retail surgery. You're not treating sick people, we're not treating people who need to have pathology addressed. This is the surgical or medical end of the beauty industry, and the doctor as the performer is not doing it for altruistic reasons – nobody has a calling to doing cosmetic surgery – they do it because they like it, they enjoy the environment and it makes them a good living* (Fleming, in NSW HCCC 1999, p. 170).

From this perspective, it is not surprising that cosmetic surgeons were early contenders for exploring the promotional flexibility that became increasingly available to doctors from the mid 1990s as a result of the implementation of National Competition Policy. This is a development that has given rise to concerns about the ethical practice of medicine in general, and is of particular relevance to cosmetic surgery. The then NSW Health Care Complaints Commissioner (Walton, 1998) suggested that adherence to the Competition Principles Agreement places doctors in a situation of conflict because they are balancing *economic prizes with patient welfare* (Walton in Ring, 1999a, p. 20).

Medical practice, National Competition Policy and the right to advertise

From the mid 1990s, the Australian Competition and Consumer Commission (ACCC), as the operational arm of the National Competition Policy, has worked to ensure that doctors have the same competitive rights as other businesses. It has been instrumental in bringing about the deregulation of the previously outdated restrictions imposed on advertising by doctors (Ring, 1999a, 1999e). The Australian Medical Association (AMA, 1999) in a 1996 position statement on 'Advertising and Endorsement' has noted some reservations. The following concerns were included:

> *Promotion of a doctor's medical services as if the provision of such services were no more than a commercial product or activity is likely to undermine public confidence in the medical profession. Over time, this may diminish the standards of medical care which patients have a right to expect* (p. 2).

As foreshadowed earlier, cosmetic surgeons have presented a valuable test case of the validity of such concerns. Their reduced reliance on the referral system in the absence of a Medicare rebate, together with their practice of targeting healthy people as potential consumers, has resulted in their being the first sector of the medical profession to make the most of new opportunities to advertise in the same ways as other commercial businesses (Ring, in NSW HCCC, 1999).

The lengths to which some of the more entrepreneurial doctors have gone to achieve this was the stimulus for another set of concerns targeted by the NSW Inquiry into Cosmetic Surgery, regarding *the way cosmetic surgery procedures are promoted* (Committee of Inquiry, 1999, p. 1). The images and messages used in the promotion of cosmetic surgery in various forms of the media have been described by this author in a number of arenas [eg Ring, 1998; Ring, in NSW HCCC, 1999; Ring, 1999a, 2000]. The questionable techniques used, include a strong focus on ideal body images and on misleading before-and-after pictures, particularly targeting women as the primary group of potential consumers. These techniques are described in more detail in Chapter 5, while the targeting of women is discussed in a later section of this Chapter. The accompanying illustration (from *The Courier-Mail*, October 26, 1999, p. 3) shows one instance of the ways in which models are being used in cosmetic surgery advertisements, together with the advertiser, a cosmetic surgeon who has *rejected criticism of the photograph* (Vale, 1999, p. 3).

During the NSW Inquiry (1999), its Committee identified a disturbing use of dubious advertising practices by some doctors and made two compensatory recommendations. A number of practices were considered to be in possible *breach of professional standards and fair trading laws* (p. 60). These included the misleading use of models in illustrations such as the example from a Queensland newspaper shown here; enhanced and otherwise misleading use of before-and-after photos; misleading impressions about medical qualifications; unrealistic claims minimising risks and maximising benefits; unsubstantiated endorsements; and blurring of *the line between advertising and information [in] advertorials in popular magazines and television* (p. 60). The recommendations were:

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Cosmetic surgeon's model under fire; with photography by Paul Wager, The Courier-Mail, and with captions as featured in the edition of October 26, 1999, p. 3.

> *19a. The ACCC and the HCCC develop a guide on the application of fair trading laws to the promotion of health services,*
>
> *19 b. The impact of the guide be monitored and a report on its impact and an assessment of the need for a mandatory industry code be made within 18 months of release of the guide* (p. 60).

Such guidelines have been previously developed to assist particular industries to:

> *...comply with the Trade Practices Act, especially misleading and deceptive conduct provisions...[and] while there is no guarantee that the courts will apply everything in the guide, people who choose to ignore the guide may find themselves at greater risk of prosecution by the ACCC or another regulatory body* (p. 59).

Acceptable advertising practices versus trust

A draft document of guidelines for doctors regarding acceptable advertising strategies was developed and circulated for comment in late 1999 (ACCC/HCCC, 1999). The focus of these guidelines is on those practicalities and limitations to advertising that are determined by the Trade Practices Act. What they do not take into consideration, are the more fundamental and less tangible issues associated with the development of a position of trust by doctors. The potential for some doctors to exploit that position is of concern, and this needs consideration in light of what is deemed as acceptable commercial practice. One example which is couched in ambiguous terms, is the advice regarding the practice of self-evidently exaggerated statements of opinion (not fact), or *puffery*. This is not prohibited because *this will not mislead anyone*, but requires *great care* in the case of *complex subjects like health care* (ACCC/HCCC, 1999, p. 10). One could question if a cautionary caveat is sufficient in the case of doctors in general, and cosmetic surgeons in particular. When a consumer's decisions can affect their health and well being, any degree of exaggeration or puffery may not be acceptable, and may be not only irresponsible but also potentially misleading. The expectation that a certain level of exaggeration will be 'self-evident' is a risky proposition in the area of health. Some consumers of medical services *may not discern the difference between medical honesty and what could be regarded as dishonesty under a more acceptable label* (Ring 1999d, p. 5).

It is relevant to note an observation made in the context of the disproportionately high number of misleading advertisements generated by plastic surgeons in the USA. There, it was found that: *Despite several well-publicized exposes, Americans remain fairly unsophisticated when it comes to making sense of medical terminology and evaluating physicians' credentials* (Haiken, 1997, p. 294).

Acceptable advertising practices versus conflict of interests

There is, in addition, a complicating factor that arises elsewhere in the draft guidelines:

> *A practitioner's ability to provide dispassionate advice about the most appropriate course of action for a patient could be compromised if the practitioner has a financial interest in promoting one course of action over another* (ACCC/HCCC, 1999, p. 28).

The entry of the cosmetic surgeon into what one newspaper recently labeled a history of *dieting insanity* (Aston, 2000, p. 57) provides a useful example of how tempting it could be for a cosmetic surgeon to promote their services more glowingly than accurately. In a catalogue of 'dieting' practices from 1898 to 1998, the final entry for 1998 states that this was *the year of magic pills and plastic surgery, herbal cellulite cures, fat absorption medication and a procedure called mega-liposuction* (Aston, 2000, p. 57). Until recently, the main weight loss practices came from a variety of sources, but all involved oral strategies: that is, what was and wasn't put in the mouth. This included everything from food to amphetamines to cigarettes. In 1998, such strategies were joined by procedures which totally bypassed the mouth, and put control of the body directly in the hands of a new and powerful player – the cosmetic surgeon.

While other types of doctors have long been in the weight control game, only so much money can be made from prescribing tablets and diet regimes. However, cosmetic surgery procedures are generally costly, escalating rapidly from the hundreds to the thousands of dollars. Cosmetic surgeons are therefore in a situation in which they have a direct financial interest in promoting their own procedures over alternative remedial actions and this could well lead to what the draft guidelines refer to *as a conflict of interests* (ACCC/HCCC, 1999, p. 27).

Sexing the public face of doctors who do cosmetic surgery

In *The Beauty Myth*, there is a strong suggestion that American cosmetic surgeons are generally male. They are, for example, described *as the first men to whom technology grants the ancient male fantasy of mythical Pygmalion, the sculptor who fell in love with his own creation* (Wolf, 1990, p. 238). In the face of the *strikingly few* women practising plastic surgery, the American health historian Elizabeth Haiken (1997, p. 12) saw a *haunting resonance* (p. 12) in the title of *Dr. Pygmalion*, given by a male plastic surgeon to his autobiography. Similarly, the majority of the cosmetic surgeons who are being profiled in the Australian mass media are male (Ring, 1999e). Whatever the reasons for this, including the possibility that male cosmetic surgeons are simply more entrepreneurial than their female counterparts, the ratio of male to female cosmetic surgeons appearing in the promotional magazines that have emerged since the deregulation of advertising, is approximately 17:1 (Ring, 1999c). The majority of the entrepreneurial beauty therapists who are promoted in the same magazines, however, are female.

What these magazines also highlight is what could be described as a symbiotic relationship between predominantly male doctors, and their predominantly female patients. While there is a growing number of male patients, the ratio of female to male patients is very much in reverse proportion to that noted for female to male cosmetic surgeons. To the extent that such an imbalance occurs, it could suggest a harkening back to what has been labeled *the patriarchal medical model* [of] *masculine medicine, feminine illness* (Broom, 1995, p. 99).

Is what is seen in these magazines an accurate reflection of the demographics of practice? Are male doctors in fact more ready than female doctors to rework women's bodies? And if so, why? These questions are of far more than merely academic interest, and warrant investigation in light of their practical implications for the future of bodywork through cosmetic surgery. As the following two sections show, there is already a surfeit of information with which to answer the converse question, of why women are so much more ready and willing than men to have their bodies reworked.

Who gets it done?

It is currently difficult to get accurate Australian statistics about who undergoes cosmetic surgery, and the extent to which various groups utilise which procedures (Committee of Inquiry, 1999). Some local estimates, and the results of a survey of cosmetic surgery consumers conducted for the NSW Inquiry into Cosmetic Surgery are available. In relation to the latter, 86% of respondents were women, and 7% were aged between 15 and 24 years of age (Committee of Inquiry, 1999). It was estimated that over the previous year, approximately 50,000 cosmetic surgical procedures were carried out in Australia. In order of frequency, the most popular were: liposuction (under various labels, including liposhaping and liposculpture), breast augmentation, nose surgery, facelift, and eyelid surgery. A further 260,000 less invasive procedures (sometimes referred to as cosmetic medicine), were also estimated to have been carried out during that period (Committee of Inquiry, 1999).

More information on patterns of use is available from America. Data collected by the American Society of Plastic and Reconstructive Surgeons (ASPRS, in Howard, 1999/2000) is summarised in Table 2. There are some similarities with Australian estimates, in terms of the main procedures undertaken, and that women are the predominant consumers of cosmetic surgery. It is also interesting to compare the types of procedures favoured by specific groups. While the different sex and age groups have diverse bodily priorities reflecting differences in life stage and physiology, it is interesting to note that removal of fat by liposuction ranks in the top five procedures for all groups.

Most of the popular cosmetic surgery procedures are costly in Australia, and many are not eligible for Medicare rebate. Some, however, are eligible for rebate from private health funds, which supports Gare's perception that it is *the better off among us [who] are also getting better looking because they can afford to buy beauty* (Gare, 1999, p.10). In the American heartland of cosmetic surgery, it was recently reported that economic hardship was not necessarily a barrier and that for the many patients who *struggle to cover the cost… loan companies now offer monthly payment plans for body work* (Figueroa, Downey, Sieder, Lauerman, Pierce & Roberts, 2000). In light of that observation, it is interesting that a consumer survey carried out for the NSW Inquiry into Cosmetic Surgery found that over 12% of patients in paid employment were on an income of less than $20,000, a quarter earned between $20,000 and $39,000, and about 23% of those surveyed paid by loan or credit card (Committee of Inquiry, 1999). Moreover, Australian cosmetic surgery magazines are now starting to feature articles and advertisements about loan companies as *a welcome option for those who are contemplating cosmetic surgery but haven't yet been able to afford it* (in Ring 1999f, p. 13).

It is also possible to win cosmetic surgery as a prize in competitions (Committee of Inquiry, 1999). While this practice was criticised by the Committee of Inquiry, it has had a long history. In the 1920s and 1930s, for example, American *journalists and advertisers both reflected and encouraged this preoccupation [with beauty] and fed the public's fascination with the transformative possibilities of cosmetic surgery* (Haiken, 1997, p. 97) through competitions such as the *New York Daily Mirror's* 1924 Homely Girl Contest:

> ***Homely Girl Contest***
>
> *Who is the homeliest girl in New York? Daily Mirror wants to find her – for a great opportunity awaits her. A plastic surgeon has offered to take the homeliest girl in the biggest city in the country and to make a beauty of her. Daily Mirror will select competent judges to pass upon the qualities of the contestants. All you have to do is to send your photograph…Here is the chance for New York's homeliest girl. Her misfortune may make a fortune for her* (in Haiken, 1997, p. 98).

Table 2: American rankings for 1998 cosmetic surgery procedures:

Procedures	Total procedures [1,045,815]	Female proc/s [946,784]	Male proc/s [99031]	Teen proc/s [20,916]
Top 5 overall: Liposuction	1	1	1	5
Breast augmentation	2	2		3
Eyelid	3	3	2	
Facelift	4	4	5	
Chemical peel	5	5		
Others: Nose			3	1
Breast reduction		4	2	
Otoplasty				4

Note: extrapolated from ASPRS data in Howard, (1999/2000).

Why get it done?

The reasons given for undergoing cosmetic surgery range from the superficial to the structural, and can be divided into four overlapping categories: social, cultural, psychological and practical. Much of what has been written about these categories has been from the perspective of women's role in western society, and the ways in which this has cast them as primary candidates for cosmetic surgery. There is also an emerging research literature that identifies the growing importance of work on the body as a masculine concern, particularly in the latter three categories (Harkness, 1994; Bagnall, 1996; Maksan, Fawkner & McMurray, 1998). Each category will be examined in turn, in the context of the key social groups to which it applies.

The social: Predominantly applicable to women

> *To be born woman is to know –*
> *Although they do not talk of it at school –*
> *That we must labour to be beautiful* (W.B. Yeats, 1904, 'Adam's Curse')

Within this category fall all issues arising from the perspective of the body as a primary determinant of social value. This is of special and continuing relevance to women since, *despite the personal and professional gains [they] have made in recent years, appearance remains the key to women's worth* (Haiken, 1997, p. 9). There is considerable evidence, for example, that women are still more likely than men to believe that their social bargaining power is relatively low, and that their status is largely dependent upon how they look (Hayes & Ross, 1987; Wolf, 1990; McGrath, 1994; SIRC, 2000).

Clinical psychologist Ellen McGrath (1994) has suggested that this is linked with determinants of self-esteem. Specifically, she considers that external appearance is:

> *...the very root of our [women's] self-esteem and the source of how well we can expect to be taken care of in the world of men [so that] while men find their primary source of self-esteem stems from what they do and how well they perform, women's self-esteem is directly connected to how attractive we are to others* (p. 228).

This perspective needs to be considered in understanding current constructions of acceptable reasons for having cosmetic surgery. High amongst these is self-esteem, that is, doing it not for others or to solve psychological problems, but just for yourself, and to feel good about yourself (eg Anon, 1998). The possibility of a deep-seated social aetiology for problems of self-esteem is not an issue that tends to be addressed in the mass-mediated information now being generated about cosmetic surgery.

The linking of social value to appearance is increasingly dependent not only on having features and a body that are deemed 'good', but also on retaining for as long as possible, features and a body with the appearance of youth (Harkness, 1994; Haiken, 1997). 'Anti-ageing' has become the latest buzz-word in the cosmetic industries, and women continue to be the primary target as they are in the paradoxical situation of being most likely to be defined by appearance and most likely to live longer (Ring, 1999b).

Additionally, as we enter the third millennium, there is an increasing trend towards unemployment and job insecurity on the one hand (Harkness, 1994; Scott, 1998; Figueroa, Downey, Sieder, Lauerman, Pierce & Roberts, 2000), and unstable relationships on the other (Edgar, 1998). Therefore, it is likely that increasing numbers of men will also feel vulnerable enough to put themselves into the hands of people who have been promoted as being able to buy them both hope and time – but at a price (Bagnall, 1996).

The cultural: with women as the traditional targets, and men a rapidly growing focus of cosmetic industry market interest

> *It has been estimated that young women now see more images of outstandingly beautiful women in one day than our mothers saw throughout their entire adolescence* (SIRC, 2000).

McGrath (1994) has identified five powerful industrial forces as 'cultural punishers' whose enterprises are based on the 'phenomenal profits' of exploiting women's insecurities, and the consequent economic imperatives of encouraging women *to feel bad about [their] bodies and appearance* (p. 229). The first four forces and their profits were listed in Table 1. They are the diet industry, the cosmetics and toiletries industry, the fashion apparel industry and the cosmetic surgery industry. Of them all, it is cosmetic surgery that is now the most profitable in the USA. McGrath's fifth force is the mass media, whose profits, while in the billions, are impossible to determine because of its power and pervasiveness. This is due, in part, to the complexity of the media's inter-relationships with the other four forces.

What is becoming increasingly clear, is that those forces are now actively targeting males, to the point where the recent influx of magazines for men have been described primarily in terms of providing a conduit for advertisements aimed at this market (Close, 1997). There is considerable evidence that men's purchase of cosmetic goods and services is on the increase (Wood, 1989; Macken, 1993; Bagnall, 1996). While this means an increase in the use of male models to display such products, the guidelines for their selection are still very different from those used for female models. Longevity, for example, *has always been the case for male models....For some reason society sees men as growing distinguished with age, not old* (Hawkes, 2000, p. 24). More broadly, according to fashion coordinator Amanda Berry of the new men's magazine *Ralph, There is only one rule about male models....and that is that they can't look like models. Normal, everyday blokes react against that* (Gare, 2000, p. 6).

In the wider context of the mass media, there remains an even more substantial difference in the range of role models presented to men and to women. This is because men have more than enough real models to counterbalance the relatively few ideal male models, since it is still principally men who make the news. And the male movers and shakers come in all sizes, shapes and ages. Men with appearances as varied as Yasser Arafat, Juan Samaranch, Bill Gates and Kim Beazley are in highly visible positions of power and influence in government, business, war, science, technology, law, medicine, and sport. The majority of the role models for women, on the other hand, are much more likely to be ideal-bodied, young models or entertainers and others in what Wolf (1990) has labelled the *display professions* (p. 27).

The psychological: where women are the largest group suffering from body-linked psychological problems, but increasing numbers of men, and also children, are being affected

> *Body Image Depression is defined as the negative feelings of shame, contempt, and disappointment in our bodies that most women experience as we attempt to meet impossible cultural standards of physical perfection, beauty sex appeal, youth, and fashion* (McGrath 1994, p. 223).

Body dysphoria, or dissatisfaction with the appearance of the body, has been described as being of such epidemic proportions in western women (Ben-Tovim, 1996) that it could be regarded as the normal attitude to the body (McGrath, 1994). While it does not involve the dysfunctional dimensions of the more serious psychological states of body dysmorphia and pathological eating disorders, it can be a pervasive state of mind. For those who put a high value on appearance, such dissatisfaction can lead to a heightened probability of seeking a cosmetic surgery solution (Sarwer, 1997).

Varying degrees of disaffection with the body also appear to be increasingly common in men (Bagnall 1996), with links to sexuality suggested by recent research that has found that homosexual males may be more vulnerable to body image concerns than heterosexual males (Maksan, Fawkner & McMurray, 1998; SIRC, 2000). Of course, children and adolescents of both sexes are also susceptible to such concerns (Figueroa, Downey, Sieder, Lauerman, Pierce & Roberts, 2000; *Good Medicine*, 2000). Family, friends and the media have all been identified as sources of body image preoccupations from an early age (McGrath, 1994).

More generally, the need to conform, to blend into the crowd and not to stand out or look different, has been described as a major initiator of cosmetic surgery in consumers of both sexes and all ages (Davis, 1995; Yardley, 1997; Haiken, 1997; Marshall, 1998; *Good Medicine*, 2000). One of the consequences of such a need in a multicultural society, is that the distinctive ethnic features of a minority group can be a source of stress. This has been used as a valid reason for *hundreds of thousands of Americans* to undergo cosmetic surgery (Haiken, 1997, p. 175). The same author also suggests that at the very least, there is a form of tacit collusion occurring between surgeons and those patients suffering what has been labelled *ethnic or racial stigmata* (Haiken, 1997, p. 177). Increasingly, the popularity of cosmetic surgery that separately targets female and male markets in each of the key areas that define sexuality, is becoming an issue in the context of what is considered to contribute to contemporary sexual health. While the quest to enhance femininity with fuller and 'younger' breasts has had a relatively long and chequered history, augmentation has more recently been sought for other parts of the body including 'Paris' lips for women, and pectorals and penises for men (Davis, 1995; Bagnall, 1996; Haiken 1997; Sexual Health Society, 1999).

The practical: where cosmetic surgery is simply seen – by many women and a growing number of men – as an efficient means to a useful end

In the discussion of social reasons for cosmetic surgery, increasing instability in key areas of everyday life such as work and relationships was described as sowing the seeds for increased vulnerability to diminished social worth in both men and women. To the extent that this is linked with appearance, it is becoming a socially acceptable focus for remedial action that can enable the person to capitalise on advances in cosmetic surgery (Bagnall, 1996; Scott, 1998). Concurrently, there are a number of occupations in which appearance has long been perceived as an essential criterion, and cosmetic surgery as a useful adjunct, particularly for women in the entertainment and display professions. More recently, appearance has become regarded as a commercial asset in the leisure and hospitality industries, and in all other occupations where first impressions are pivotal to the job (Haiken, 1997; Scott, 1998). It is more likely to be women than men whose professional survival is inextricably linked with their looks in terms of both desirable features and prolonging the appearance of youth. Increasingly, the need to enhance opportunities by having and keeping a good appearance, is the rationale for cosmetic surgery by men in those industries *seeking an edge in a market growing increasingly competitive that shuns the ageing process* (Linnell, 1999, p. 26).

Cosmetic surgery can also be seen as simply a short-cut solution to maintaining a desirable appearance. It is used and marketed as just another, but more efficient, means of achieving an end that would otherwise be more time consuming or less effective and sustainable (Bagnall, 1996; Ring, 1999c, 1999e). Examples include the targeting of post-natal women with quick ways of getting rid of excess weight and reshaping the body; the marketing to both men and women of the increasingly popular procedure of body hair removal by laser; and the promotion of hair transplants for men to meet a need that is variously described in practical and in psychological terms.

Overview and discussion points

In considering the categories of reasons for cosmetic surgery as a sequence, they can be seen to go from the macro to the micro levels of society, from the societal to the individual. At each level, it is possible to identify the extent to which major social groups are affected. And for each level, the subtext is the question of whether, in light of outcomes to date, it is feasible to progress to effective solutions which bypass or, at least, go beyond cosmetic solutions for the situations described.

From the point of view of the way that cosmetic surgery is currently marketed, it is important to note that a very strong emphasis is put on the 'right' and the 'wrong' reasons for having it. Undergoing cosmetic surgery for yourself, for your self-esteem, or just because you want to improve your appearance, are all 'right' reasons. Having it because you think it is going to solve your psychological or social problems, resolve a crisis, or make everything about your life right, are 'wrong' reasons. The key messages are that it is right to just want to look better in some way, but wrong to think that surgery is going to solve your problems (eg Allen in Allison, 1998a). This is iterated so often in the media promoting cosmetic surgery, that it could be expected that potential consumers are primed to broach cosmetic surgery with the 'right' approach (Ring, 1999e). In the public domain, cosmetic surgeons certainly emphasise their role in ensuring that people who want to do it for the wrong reasons are screened out. The problem remains that this sector of the medical profession also acknowledges the presence of a minority of practitioners who are less than ethical, and who have sometimes been labelled 'cosmetic cowboys', because of their profit-oriented and laissez-faire attitude to the screening of patients (Allison, 1998b; Casey, 1998).

Frequent users have been given the label of cosmetic surgery junkies (Calmes, 1999), and there is evidence that supports *the commonly held view that once people start having cosmetic surgery they are likely to go back for more* (Committee of Inquiry, 1999, p. 11). A survey of cosmetic surgery consumers showed that 43% had more than one episode, with 21% having undergone procedures between two to ten times, and 4% more than ten times (Committee of Inquiry, 1999). There are a variety of reasons for this, from the practical (including the fact that a number of procedures are short or middle term in duration and need to be 'topped up' periodically), to the pathological, as in the case of people with some degree of body image disorder (Figueroa, Downey, Sieder, Lauerman, Pierce & Roberts, 2000; Calmes, 1999).

Considering the various reasons that are given for having cosmetic surgery, there are some questions that need to be asked: Are cosmetic solutions the appropriate way, or even an appropriate way, of solving the problems they are meant to address? Or are they bandaid treatments for social ills that can, or maybe cannot, be cured in other ways? These questions are the focus of increasing debate, and have prompted satisfaction surveys and other research evaluating the outcomes of cosmetic surgery (eg Davis, 1995; Committee of Inquiry, 1999). The Committee of Inquiry (1999) noted, on the basis of a review of the relevant literature, as well as its own commissioned survey:

> *The surveys generally report high patient satisfaction with cosmetic procedures...However, the Review found the published studies have methodological weaknesses...[and] were also limited because most were conducted within 6-12 months of the procedure... [Therefore] patient satisfaction surveys of cosmetic surgery using reproducible methodology should be conducted regularly,* (p. 43).

It should also be noted that the Committee (1999) reported that it *received 38 submissions from consumers of cosmetic surgery, of which 36 were complaints* (p. 19). In general, evaluation of satisfaction is made more difficult by the subjectivity involved. As Davis (1995) found, in her study of Dutch women:

> *The overwhelming majority of the women claimed that they were happy with the outcome...[even though] their satisfaction did not necessarily correspond with the actual outcome of the surgery which was, in many cases, disappointing* (p. 162).

How was cosmetic surgery in Australia transformed from an ugly duckling to a swan?

It is clear that cosmetic surgery can be constructed as a quick-fix solution for a variety of problems at all levels by both its consumers and its purveyors. It is interesting to track its social metamorphosis in Australia from a covert to an acceptable and even approved stratagem over a few decades. This can be observed by reviewing attitudes evident in *The Australian Women's Weekly*, a magazine regarded as a cornerstone of the Australian *tradition of magazine reading* (Kiely, 1992, p. 10), and *a very well-informed publication on the psyche of the Australian population* (Clive James, in Lovell, 1994, p. 8). As cited by Ring (1998, p. 91), within *The Weekly*:

> *References to cosmetic surgery in the 1970s and 80s used value-laden phrases such as 'perhaps for some very, very vain people [who want to look ten years younger]' (Manzoni, in Guinness, 1970, pp 21-22); and 'catering to vanity rather than genuine medical need' (Alderton, 1981, p. 20). In 1996, however, with its new ethos as the magazine 'for the women who want it all', the Weekly had shifted to the promotion of cosmetic surgery as a desirable option, with a new monthly column called Nips and tucks, written by 'the world renowned, Melbourne-based plastic surgeon Leo Rozner...who will provide readers with affordable information about the difference cosmetic surgery can make to their lives'* (King 1996, p. 3).

The emerging rights of doctors to advertise and promote their services has been a significant factor in this change of attitude. It has meant the ability to invest some of the profits into marketing. Since advertising is the life-blood of the commercial media, the new industry has been welcomed with open arms, and subjected to the media flair for putting a positive spin on any product. The cosmetic surgery magazines that emerged in Australia in 1998 can be regarded as some sort of apotheosis of this, to the extent that one of these magazines has created a niche for itself on the American market, in what might be seen as a truly remarkable case of taking coals to Newcastle (Ring, 2000).

Chapter 5 on advertising described more fully the ways in which, in the wider world of commercial media, the strength of the advertising dollar has been found to affect how specific products are referred to in the editorial sections of media featuring their advertisements. The most substantially documented evidence of this was collected in the 1980s. This demonstrated an association between the presence of cigarette advertisements and the extent to which information about the harmful effects of smoking was suppressed in a variety of media, but most especially in women's magazines (eg Silberberg & Magnus, 1989). There is also a considerable amount of literature highlighting other ways in which advertising influence has been brought to bear in various ways. A key factor is the reality of what McCracken (1993) has described as covert advertisements, which involve explicit financial arrangements for the promotion of products within editorial sections of the media. The 1999 'cash-for-comment' case involving talkback programs on a NSW radio station is the most recently publicised example of this in the Australian context (Ring, 1999g). Both McCracken (1993) and Wolf (1990) had highlighted such practices involving the cosmetics industry. The possibility of these influences being brought to bear by any economically powerful advertiser is, therefore, a legitimate concern.

Because of such possibilities it would be appropriate, as suggested to the NSW Inquiry into Cosmetic Surgery, to scrutinise and monitor the financial, as well as any other less formal, arrangements involving advertisers in the new cosmetic surgery magazines (Ring in HCCC, 1999). This is particularly important in light of the overtones of a de facto advertorial structure in the content of these magazines. A consistent finding within single issues of these magazines was the presence of both feature articles and advertisements that promoted the same services and named service providers and products (Ring, 1999a; Ring, 2000). The possibility of covert arrangements and influences occurring in the more complex structuring of multi-media corporations could also be appraised, in view of the potential for advertisements to be inserted in one medium, and simultaneous features about what or who is being advertised run in another.

It is important to sound this cautionary note, particularly because the media has been reported as being one of the main sources of information and stimuli for action with regard to both cosmetic surgery procedures and specific practitioners (Committee of Inquiry, 1999). It should also be recognised that the increasing use of cosmetic surgery started well before the change in its public image. The situation that Haiken (1997) described in the American context also has relevance in Australia:

> *The patients…[from the 1930s and 1940s, and today] who…insist that cosmetic surgery will cure their inferiority complexes or, in current terminology, improve their self-esteem, must also be considered responsible. Without the thousands of Americans who begged their surgeons to devise solutions to the problems that distressed them, cosmetic surgery would not be the phenomenon it is today* (p. 300).

What this change does mean is that consumers are now ready to admit to having had cosmetic surgery rather than keeping it a secret (Linnell, 1999), and potential consumers have more ways of finding out about such surgery (Committee of Inquiry, 1999). The wider population is more directly exposed to a variety of positive promotional material about its benefits, including the full force of an advertising industry with a sustained tradition of creating needs by inducing insecurities and playing on people's vulnerabilities (Windschuttle, 1988).

Does the scope of cosmetic surgery give new meaning to the notion of the body as a work-in-progress?

In her history of cosmetic surgery in America, Haiken (1997) draws a conclusion which serves as an unequivocal 'yes' to the question of cosmetic surgery's contribution to the body as a work-in-progress:

> *If we look carefully, we see that, in cosmetic surgery, medical and cultural values have intertwined to produce a practice that subverts our most cherished hopes even as it seems to fulfil them, that is both cause and consequence of a loss of faith in the possibility of transformation on a broader scale….For Americans and for their cosmetic surgeons, the individual, external self offers a last, and apparently everlasting, frontier* (pp 300-301).

More narrowly, she suggests that *cosmetic surgery lies at the nexus of medicine and consumer culture* (Haiken, 1997, p. 12), and can be linked with an earlier perspective of the body within consumer culture as proposed by Featherstone (1982):

> *The instrumental strategies which body maintenance demands of the individual resonate with deep-seated features of consumer culture which encourage individuals to negotiate their social relationships….Self preservation depends upon the preservation of the body within a culture in which the body is the passport to all that is good in life. Health, youth, beauty, sex, fitness are the positive attributes which body care can achieve and preserve* (p. 26).

Stewart, Eckermann and Riggs (1997) have extended this and propose the importance of recognising that *bodies are central to individuals' modern lives and that the body is now subject to any number of interventions in its role as a project of the self* (p. 140). In other words, it is continually being worked upon.

It can be seen that preoccupation with appearance can be a lifelong commitment. Not only are the reasons for this pervasive and multi-dimensional, but the types of concerns can shift and vary over time. In practical terms such concerns can be categorised into three main, overlapping sets or clusters:

Set 1: Concerns about beauty or good looks that are dependent on having desirable features, principally of the face and hair

Set 2: Concerns about size and shape of the body

Set 3: Concerns about looking young or, at least, youthful

The specifics of any concern can vary with the fashions of the time, but more fundamentally, different life stages can heighten awareness of different elements of the body. The first two sets of concerns can start early in life, with the second set having the potential to ebb and flow with eating habits, exercise patterns, and life experiences such as pregnancy. This leads on to the third set which can be affected by time and the changing distribution of body shape. As a cluster of concerns, however, Set 3 can be expected to increase with the progressively more visible effects of age on skin and muscle tone, hair colour and amount, and body shape. It is not surprising that Wolf (1990) has described this set of concerns as a prime target for cosmetic surgery, with a marketing strategy that reclassifies ageing as *ugly, and ugliness as a disease*, and for which cosmetic surgery practitioners have the most effective treatment (p. 234).

While various sectors of the traditional cosmetics and body management industries consistently offered a variety of solutions to these concerns (having contributed to their construction as problems to be solved), often their solutions have not fulfilled their promises (*Choice*, 1998; Egger, Cameron-Smith & Stanton, 1999). The technologies currently supporting cosmetic surgery are at a stage where a procedural solution can produce an almost immediate effect. This may, at least, be the case in the short or middle term, and is available for many perceived appearance problems in both women and men of almost any age and stage (*Choice*, 1998; Haiken, 1997). The more effective the particular procedure has been for a person, the more likely they are to return for more top-ups, to firm up, or to check other flaws (Figueroa, Downey, Sieder, Lauerman, Pierce & Roberts, 2000).

Images to look up to

Despite the medical context framing cosmetic surgery solutions, the strategies used to promote them include the same two types of visual messages used by the traditional cosmetics industry. In summary, these are:

- *The lure of the ideal, through the use of models who already represent an ideal that is unattainable by the average person, and whose pictures are typically further fine tuned to a level of unreal perfection in a variety of technological ways* (Cooke, 1997; Bentley, 1999), and
- *The promise of improvement, through the use of before-and-after pictures of real people who inevitably look better afterwards (in part because the 'after' shots have, in the main, also been enhanced in a number of additional ways)* (Ring, 1999a).

Separately or in combination, these messages underpin a variant of what can be described as 'planned obsolescence'. Specifically, these messages are an extremely efficient way of simultaneously exploiting and contributing to the commercial enterprise of programming discontent with physical appearance. While it does not require an Einstein to identify the main targets of this 'programmed discontent', the present author has taken the liberty of adapting some of his terminology to sum them up in Ring's 'Theory of Cosmetic Relativity'. This theory, which has particular relevance for societies where appearance is significant, states that:

> *Since the standards for appearance are relative rather than absolute, work on the body need never be done because:*
>
> *[i] as a general point, all of us can look better than we do, no matter how good any one of us actually looks; and*
>
> *[ii] in terms of specific attributes, there is always some part of the body that could be improved on because it doesn't look quite as good as somebody else's, or as the former self's, or, most unrealistically, as some unattainably idealised image of perfection.*

Even though this is not rocket science, it has some explanatory power for the exponential growth in the practice of cosmetic surgery as a powerful contributor to effective modifications of the body as a work-in-progress.

Whither cosmetic surgery?

Cosmetic surgery has become the focus of considerable attention in a variety of domains such as the academic, health professional, and policy sectors of our society as well as the media and the wider community. Various speculations can be made as to its future directions regarding the ways in which it is practised, and promoted, and its role, applicability and prevalence in society.

The NSW Inquiry into Cosmetic Surgery: Targeting a disease, or just its symptoms?

An important contribution to some of the key practicalities of cosmetic surgery was made by the NSW Inquiry into Cosmetic Surgery. As seen earlier in this Chapter, its terms of reference restricted its scope to issues pertaining to standards in the areas of professional practice and training in relation to the health and safety of consumers. It also considered the strategies used to promote, advertise and inform about procedures and practitioners. Its recommendations are now being examined by the other States (Kennedy, personal communication, 2000), and were formulated to ensure better standards, safety and ethical approaches in the practice and promotion of cosmetic surgery. To achieve these objectives, its 11 person

Committee had a preponderance of medical representatives. The Committee comprised eight male doctors, a male government official, a female consumer representative and the female Chair (the then Commissioner of the Health Care Complaints Commission).

Deeper questions remain, that go beyond the Inquiry's brief. These relate to the implications of a growing, and possibly predominantly male dominated sector of the medical profession becoming not only de facto members of the cosmetics industry, but amongst the highest income earners of an industry that feeds off the insecurities of large sectors of the community, particularly women. This Chapter concludes by considering some of these implications through three different scenarios for the future of cosmetic surgery. The first two of these are well within the realms of possibility, while the third involves a substantial stretch of the imagination.

Body appearance becomes medicalised

In this scenario, looking sick would assume a new meaning by coming under the control of 'medical healers of sick looks'. In other words, various types of appearance differences would be re-designated as illnesses, as is already being described in the American context. Haiken (1997) suggests that in this context, plastic surgeons have contributed to the process of medicalisation:

> *...by inventing new names for a growing number of deformities:*
>
> *"bat wing deformity" is characterised by "redundant skin and tissue hanging from the upper arms";*
>
> *"spare tyre deformity" is defined by excess adipose tissue around the waist and abdomen; most commonly,*
>
> *"violin deformity" (also called "saddlebags" or "riding breeches") is characterised by deposits of adipose tissue on the lateral (outer) thigh where it meets the hip* (pp 299-300).

Beyond the issue of what does and does not constitute a 'deformity', the WHO perspective on health provides a wider framework within which there has been some legitimisation of a health role for cosmetic surgery. This has been rationalised by arguing that cosmetic surgery contributes to the positive health status defined as *complete physical, mental and social well-being* (Haiken, 1997, p. 6). More bluntly, cosmetic surgery has also been described as *psychiatry with a knife* (Rozner cited in Cooke, 1997, p. 159). Such perspectives again raise the question of appropriate versus inappropriate candidates for surgery. There remains an absence of literature about indicators for patients for whom there are contra-indications for psychological reasons (Committee for Inquiry, 1999).

If there is a move towards a reconstruction of cosmetic surgery as part of conventional medicine dedicated to the health of patients, rather than being an individual's choice about personal appearance, then there would need to be associated changes at the policy level. It would be appropriate to review the full set of cosmetic surgery procedures to consider whether they do belong on the Medicare list of scheduled items. If this were the case it would have the consequence of re-instating some of those economic constraints on practice that were effectively removed in the 1980s.

Cosmetic surgeons become demedicalised

Alternatively, cosmetic surgeons could become re-designated as medically trained beauty therapists, with all the prerequisite skills, and conforming to whatever standards of safety, training and practice are set by society, but without the trappings of traditional medical ethics and rationalisations. The doctor-patient relationship that was previously based on trust, and the expectation that the patient's well being was the doctor's priority would be replaced by the commercial caveat of 'buyer beware' (Ring, 1999a).

That was the scenario projected for the future, in *Gloss*, a very short-lived, late 1990s anti-ageing magazine for women. Cosmetic surgery was put fairly and squarely in a 'cybernetic beauty salon', with 'therapist robots' as an alternative to surgeons, and new 'beauty technologies' to reshape the body. The *coup de grace* given to this speculative line of reasoning was the projection that by 2090 one would be able to pick up a new body *like a hire car* (George & Dickens, 1998/99, p. 66).

Cosmetic surgery in decline as the appearance of the body becomes revalued and devalued as a social imperative

In this scenario, cosmetic surgery and the body image industries as a whole would experience a degree of attrition. This would occur as society revised its current perception of appearance as a primary social value, and gave greater emphasis to what Haiken (1997) referred to as *transformation on a broader scale* (p. 301). This would be associated with a more balanced view of the body as a part of, but not the dictator of self. This scenario begs the question of whether body dysmorphia and other states of dissatisfaction with the body are deemed to be the symptoms of a physical, a psychological, or a social disease. We need to determine this point because without knowing the aetiology of the disease we can not be confident that we are treating its symptoms appropriately.

In determining an answer, and because Australia seems to be taking up the American model of cosmetic surgery, it is appropriate to conclude this Chapter with some summative comments made by Haiken (1997), as the historian of that model:

> *In one sense, the widespread adoption of the surgical solution reveals a frightening vision of Americans as conformists, bent on achieving a commodified, advertising-driven standard of perfection...[However] given the complexity of the modern world, it is not surprising that individuals conclude that it is easier to change the self: the problem, in other words, clearly lies with the world, but the easiest solution, just as clearly, lies with the patient. But in our readiness to define the problem as too complex to handle, we have encouraged the belief that*

the only practical solution is the individual one. Our increasing tendency to individualise social problems of inequality suggests just how fundamentally we have lost faith in the possibility that commitment and collective action can transform the society in which we live (p. 15).

Postscript:

The synergy that has developed between the body as work-in-progress and idealised images of the body is encapsulated in models who undergo cosmetic surgery to enhance the advertising value of their ideal bodies.

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Chapter 9 – Lycra and the Manufacture of Difference in Televised Sport

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Helen Waite

This paper is an examination of the representation and presentation of women's and men's bodies in the sports of basketball and track and field and the sociocultural context in which this occurs. Our sporting fields and courts are one of the last sites of struggle and resistance to the gains of the women's movement in relation to women's autonomy over their bodies, equality in the workplace and labour market, gender relations and professional sporting involvement.

The gains of women athletes

After the social, cultural, physical, psychological and economic constraints on girls and women in relation to serious participation in elite level sports, the last decade has seen a rapid growth in the number and visibility of professional women athletes. It is in the very processes which have created this visibility and presence in popular culture and professional sport that particular representations of the bodies of elite women athletes are being manufactured. These women's bodies are now subject to the gaze of the television camera and the scrutiny of large numbers of spectators.

Apart from the economic context, Australia has a growing number of elite women athletes partly because physical education and sport are compulsory and significant aspects of both the primary and secondary school curricula. Girls are being encouraged to participate and to continue their participation through to elite levels in major sports through various scholarship schemes, particularly at the Australian Institute of Sport. The two sports dealt with in this paper are both part of this national scholarship scheme to encourage girls into elite level sport.

It was in 1971 that the cigarette company marketing Virginia Slims first sponsored a professional women's tennis circuit. At the forefront of the campaign for equal pay in international tennis and professionalism in women's tennis, was Billy Jean King. It needs to be noted that the importance of differentiating the female physical body on the professional sporting field or court has been an issue from the outset of professionalism. Billy Jean King as president of the women's tennis union urged all players to be *as attractive and feminine as possible* by urging *all members to wear tennis dresses or skirts*, because apart from the importance of appearances in counteracting lesbian stereotypes, the *fans are so close to the players. And certainly we offer something for everyone's physical taste [in women's bodies]*(King, 1982, p. 137).

Despite being considered a leading women's libber at the time, her justification is both 'moral' and economic:

> *I think tennis is a very sexy sport and that is good. The players are young, with excellent bodies, clothed in relatively little. It offers the healthiest, most appealing presentation of sex I can imagine and we in sport must acknowledge that and use it to our advantage* (King, 1982, p. 136).

Despite this advice being taken by women tennis players who, even now, rarely play tournament matches in shorts, women's sports receive very little media coverage compared to men in the same sport at the same level. If it weren't for the ABC there would be very little access for viewing women's basketball, netball, hockey or cricket. In addition, women's access to a number of sports and events at the level of Olympic Games is still not complete. Women were allowed to compete for the first time on the dates indicated, in the following sports already in the program for men:

Basketball	1976
The marathon	1984
Hockey	1984
Cycling	1984 but only one event
Judo	1992
Pole vaulting	Not yet

It should also be noted that in 1980, the longest track event for women was 1,500 metres.

Some reasons for increased participation

The growth and influence of the women's movement created a climate and often the legislative framework which facilitated women's participation in elite level sport. Participation was the embodiment of some the fundamental principles of autonomy, choice and control over one's body. Increased labour market participation by women and reproductive control and choice also expanded the range of career options and aspirations. Entry into higher education in greater numbers and access to sporting facilities in these institutions created further opportunities for serious participation in sport for some young women. Equal pay and anti discrimination legislation meant that some of the structural barriers for women wanting to train, were reduced. In addition as a result of the women's movement renegotiation of personal relationships, and or parenting responsibilities and women's personal goals was possible, creating the possibility of more time for sports practice.

Along with these social and cultural changes over the past two decades the Australian economy has also undergone significant changes. There has been the usual imperative to expand consumer markets to maintain profitability. The increased participation of women in sports creates new consumers for a whole range of goods and services. This trend along with the rise of 'healthism' has seen a rapid growth in the leisure and sports industries, with specialist fashion, footwear and equipment becoming significant consumer items, often moving off court to become street fashion. The reduction in working hours to 38 and shifts from manufacturing to service industries, have also played a part in enabling the increased participation of women in sport. Not least of all, has been the increasing levels of pay for professional athletes and the opportunities to supplement prize winnings and weekly salaries with contracts from companies such as Nike or Coca Cola for endorsements and advertisements. At the ideological level there are a number of process and forces at work which have contributed to the rise in the profile of professional women athletes. Many projects and programs throughout Australia encourage young women to believe that 'girls can do anything', particularly in relation to non traditional career choices and school subjects, usually as part of an affirmative action policy. There has been increasing emphasis in public health and at the popular cultural level, through lifestyle programs such as Good Medicine and Healthy Wealthy and Wise to individualise health problems. One of the ideological underpinnings of this asocial and apolitical perspective on health is to position individuals as entirely responsible for their own health outcomes. This ideological position has grown into a moral imperative where to keep fit, or at least be trying to and to exercise is considered a 'good' thing. Not to exercise is 'bad' and irresponsible at both the individual and social level. Young women then, have an admired and socially valued avenue to stay 'thin'. Sport and exercise can be appropriated as a healthy way to stay thin, often dangerously and unhealthily thin. Finally, in terms of the state, Olympic and international sporting success in times of relative peace is the main cultural practice for the maintenance and reproduction of 'nationalism'. Obviously with increasing numbers of international competitions, women athletes too will be encouraged and supported by the State, though agencies such as the Australian Institute of Sport. This 'equal' and in many cases greater contribution of women athletes to medal tallies, is another factor contributing to greater participation but it also becomes a site for those processes involved in 'manufacturing' difference between male and female athletes.

The Australian sporting context

In the Australian sporting context, a number of trends are apparent in which gender differentiation is significant.

Firstly, despite the progress and profile of a number of women athletes, for many parents with sons, body contact and/or highly competitive power based sports are considered to be the main avenue for establishing masculinity and so they encourage participation from a very young age in such sports such as rugby league and union, Australian rules and more recently basketball. Among young boys themselves it is important to their public image as boys/men to learn how not to throw like a girl, a comment which is used to denigrate the sporting performances of boys. Despite the prominent footballer, Ian Roberts, declaring that he is gay, in the Australian context there is still a close nexus between heterosexuality, aggressiveness and extreme competitiveness called the 'the killer instinct' embodied in many male sports and equated with hegemonic masculinity. I am arguing that sport is a most powerful and effective social practice for achieving these more political outcomes and reproducing a particularly narrow world view. This occurs in such a way that sport seems to be a perfectly natural expression of human nature and the contents and assumptions of sporting practices are taken for granted by many individuals regardless of their other social characteristics such as class, gender, ethnic background, age, or geographic location. One avenue for exploring these processes is to critically examine the language (verbal and non verbal) of sports reporting and commentary, as well as that of the athletes themselves. The language of sport commentaries and sports journalism are also representations of the symbolic power of a particular form of masculinity, in which there are attempts to maintain gender distinctions. If you take out the ads from the daily tabloids, sports reporting makes up the greatest proportion of content; bigger than local politics or overseas news. However the reporting of women's sport occupies on average less than 1% of this space. It is clear we are dealing with a gendered organisation of life, in which is seems important to maintain the differences between women and men by emphasising displays of power and control, not grace and elegance. During the American open tennis tournament in 1996, there were several Australians entered. One was Mark Phillipoussis. The heading reporting on one of his matches was Scud's Missiles. His serve was described as BOMBARDING his opponent with SERVICE MISSILES in the 210K's HOUR RANGE and he closed out the match with AN ACE THAT WAS SMOKING. In all he was reported as having LAUNCHED 24 ACES and another 10 service winners that left his opponent only guessing where the EXPLOSIVE WEAPON WOULD LAND. In reference to another Australian's match in the same article, it was reported that another of the big BOMBERS, Ivanisevic also cranked up his serve. Draper received the THUNDER BOLTS. Draper lost his match. Mark's nick name is really SCUD and Pete Sampras, the eventual winner, has the nick name PISTOL PETE, again a reference to the speed of his serve. All of this in a single report about a tennis match, a seemingly low aggression, low violence sport, and in the same week, the

US launched missiles not tennis balls into IRAQ. In my observations such world events make no difference to the level and content of military metaphors and violent symbolism used in sports reports, although I have noticed ANZAC themes are frequently used in sports reports on the ANZAC long weekend.

I would argue that the recurring themes in the language of sports reporting, connects particular behaviour with particular types and expressions of masculinity. It privileges and legitimates a violent form, and connects this aggression to success, status and respect as a male. In doing so it largely excludes women, except as supporters of this particular arrangement of gender relations, and it ignores and devalues non-aggressive cooperative forms and expressions of masculinity, even in non-violent, non-contact sports such as surfing. Pistol Monica or BOOM BOOM Stephie or Scud Martina somehow is very jarring. In this jarring of the words, it is possible to recognise how easily and frequently the hegemonic male view in sport is taken for granted and the processes by which this occurs remain largely unchallenged in any fundamental way. Part of the reason for the heavily military and aggressive masculine language of sports over the past 15 years is part of the 'manufacture of difference' between men and women as a reaction to the gains of the women's movement. The increased participation of women across all sectors of society, including elite level sport, means the areas of difference between women and men are now reduced to the physical. The actual bodies and physical activities of women and men are one of the few remaining unambiguous areas for the maintenance of 'difference' between the genders. Sport is the area of a final ideological struggle. Women are not winning.

Objectification of the body

One of the processes essential to supporting aggressive hegemonic masculinity is objectification. Objectification of the athletes themselves and objectification of their opponents through the creation of a depersonalised enemy, deserving of annihilation at all costs. The objectification of women's bodies is also apparent in the sporting arena with athletes' bodies often referred to with some machine analogy - like well oiled machines or robotic laps. The process begins in schools with PE teachers who allocate children to teams, which have a name and a colour to be worn at all competitions against other 'houses' with points allocated at carnivals to the best war cries. In the creation of this house spirit which was easily converted to school spirit and even state spirit, children are taught to identify with their country, and develop feelings to be drawn upon so easily during Olympic games and other national competitions. The process involved connecting feelings with events and feelings with 'us the good guys' and the others as the enemy: Being able to believe that other people deserved to be beaten and the good guys deserved to win. What is this thing 'national pride'? It is learnt through sporting culture even if you can't serve your tennis ball into the right section of the court. With objectification it is very difficult to think about and consider other perspectives, women as athletes in their own right rather than female bodies for male consumption or even peaceful solutions to conflicts because the opposition is frequently framed as a depersonalised enemy.

It is therefore not surprising that in Australia, there are very low levels of male participation in such sports as ice skating, gymnastics or diving. In addition, there has been a recent rise of what I would call muscular masculinity, in many popular cultural forms such as sports and film (eg Stallone, Van Damme, Schwarzenegger versus John Wayne). Here muscle size and definition rather than the sports activity or power alone are most significant in differentiating men from women athletes. For instance the rules of body building for women penalises muscle size. Consequently women such as Bev Francis do not win competitions because they have muscle size and definition that is considered unfeminine under the rules. See, for example, a photo of Bev Francis in Gaines and Butler, 1984, p 158.

This trend places some women athletes in 'men's' sports such as basketball, marathon running, and pole vault in very contradictory positions and at the cutting edge of gender struggles. The women are showing confidence in their bodies, high degrees of athletic skill, often earning much more than women in other careers, being admired for their skill and achievements but being sexualised in the process as they also need to gain sponsorship and media coverage. The cost appears to be the display and presentation of what I would call 'athletic femininity' through the use of lycra uniforms.

Various dimensions to this struggle are apparent through a consideration of the actual bodies and appearance of women and men who are engaged in the same sport, such as basketball. High profile sports such as this are televised nationally on a weekly basis and therefore comprise a significant source of images of materially valued and socially admired male and female bodies. The manufacture of difference and differential sexualisation of women and men as athletes has been possible particularly through the use of lycra clothing and uniforms for women in a context of the increasing dominance of muscular masculinity in sports.

Lycra and women athletes

About six years ago, women basketballers at the national level began to play in lycra uniforms, but this did not happen in other countries. The American women's team do not wear body suits but shorts and singlets the same as the men's. See, for example, a photo of both teams in *Women in Sport*, 3:3, p 55. Men have only worn lycra for sport when there has been a performance advantage in speed events such as in the 100 metres sprint, cycling and speed skating.

What this has done, as male basketballers play in baggier and baggier non lycra uniforms and women play in more revealing and tight fitting lycra ones, is establish difference in the same sport. This is despite the same rules, same court, and same skills being used, but not the same TV/media coverage (see photo in *Inside Sport* pp 76 and 79).

The same is true of marathon running, until recently a male only event but now involving the same event, distance and skill but different uniforms. Only women run in lycra body suits, while the men run marathons in loose fitting shorts and singlets (see photo of marathon runners in *Inside Sport*, pp 54 and 55).

The most recent male only event to be taken up by women is pole vaulting and once again lycra is given a crucial role, but only for women with Emma George in a two-piece, bikini like uniform, while the male world champion pole vaulter, Bubka, jumps in loose shorts and a singlet which covers all of his midriff (see, for example, *Women in Sport* 3:3 front cover and pp 14 -15).

The basis of the difference is to accentuate the biological and physical differences between women and men basketballers, something which cannot be altered by EEO or anti discrimination legislation, or positive social attitudes towards women's full participation in the world. At another level, the lycra also attempts to establish feminine heterosexuality - women basketballers look like 'real' women' - you can see for yourself on TV, you can see the female details of their bodies. Women playing in the baggy shorts and sloppy singlets of the men would not have the same symbolic or visual value and would leave the sport more open to the old stereotype of women athletes as being lesbians, and therefore less attractive to potential sponsors. Lycra then, maintains traditional gendered and sexual categories whilst developing 'athletic femininity'.

Women's bodies in these sporting contexts are still for public consumption but they have different content. In this sporting content, it is likely that a new orthodoxy may develop around the real and actual bodies of women. It is a new aesthetic in relation to women's bodies which now includes a little muscularity and athleticism that is in stark contrast to that of the fashion model. This different, but same approach to the public presentation of women's bodies is finding favour with a number of companies, all of which are willing to sponsor various women's sports: eg Diet Coke, Cenovis Goldmark, Foxtel, and the Sydney Casino.There is much less anxiety and therefore lycra around traditional women only sports such as netball, although with increasing media coverage this could change. Compare the photo of the Australian netballers with that of the Australian basketballers referred to above. I would argue that because the public gaze is gendered, they too will come to wear more and more revealing lycra uniforms (see *Women in Sport* 3:2 pp 36-37 and pp 54-57). Consider one of Australia's best known basketballers and ask yourself: 'Why won't Andrew Gaze (or his sons) ever wear lycra body suits to play basketball?'

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Part III: Treatment Issues – A Multidisciplinary Perspective

Today, in developed countries such as Australia and New Zealand, anorexia nervosa is the most common serious disease of adolescent girls and young women. This is a big claim to make, but it can be justified....The mortality rate...is about 20% at 20 years. This is completely unacceptable for a disease whose sufferers have an average age of onset of 17 years (Beumont, Chapter 10).

Chapter 10 – Anorexia Nervosa as a Mental and Physical Illness: The Medical Perspective

Pierre Beumont

Much attention is rightly given to the social and cultural context of disordered eating, and to its relation to the contradictory pressures to which young women in particular are subjected in our society. An understanding of the experiences of these young women is derived from various perspectives, including importantly the feminist perspective, and anorexia nervosa is considered as part of a spectrum of disturbance that includes bulimia nervosa, binge eating disorder, and obesity. All of these conditions, known collectively as the eating disorders, are common and important health concerns, and are properly the subject of a public health debate in which there are many legitimate stake-holders: consumers, carers, nutritionists, educationalists, sociologists, psychologists and health professionals among them.

It is useful to distinguish two groups of conditions among the eating disorders: those in which the disturbance of behaviour appears to derive primarily from attempts to limit energy intake, with detrimental effects of various types, and those in which there is no apparent restriction. The first may more properly be called dieting disorders. Many obese people, most commonly those women whose obesity arose in childhood and adolescence, give a story of repeated attempts to control their weights by rigid dieting, followed by periods of overeating during which it is rapidly regained. It may be that the degree of obesity is augmented by these periodical diets, each new peak in weight being higher than the previous level. Then there are those who alternatively restrict and then have phases of reactive overeating known as bulimic episodes. These episodes are followed by various compensatory behaviours such as purging, vomiting, exercising or self-starvation. Their body weights are usually within the normal range. Third are those in whom attempts to restrict energy intake are too successful, who become emaciated as a result of food restriction and excessive exercise, in many instances combined with self-induced vomiting and purging. These patients have anorexia nervosa, of the restricting or purging sub-types.

From a public health perspective, the difference between dieting disorders and other eating disorders is important. For the latter, the provision of nutritional information and encouragement to eat moderately, restrict the high energy component of the diet, to include the important minor nutrients, and exercise regularly are the obvious strategies. Without firmer and more consistent self-control, obesity will persist. Unfortunately, many who would most benefit from this advice do not adhere to it, making obesity a major and increasing health problem in developed communities throughout the world. But the same advice is accepted all too readily by those with dieting disorders, and its distortion and exaggeration is part of their problem. It is time that workers in the obesity field and those dealing with anorexia and bulimia nervosa come together to provide an educational program that is appropriate for both the obese and those with dieting disorders.

Dieting disorders are most prevalent in adolescent girls and young women. This fact probably accounts for the great attention to which they have been subjected by the sociologists, psychologists, feminist thinkers, social commentators and the general public. Attempts to understand the plight of the dieting disordered woman receive much greater priority in the popular press than attempts to understand the plight of the middle-aged obese man, the nicotine addict risking carcinoma and emphysema, or even the plight of the alcohol dependent person. Understanding the social, sexual and psychological content of these conditions is extremely helpful, but more restricted scientific explanations should also be sought. There are some biological factors that should always be born in mind when asking questions such as: Why women? Why adolescents and young women? Why only some who are affected while many are exposed to the same risk factors?

Almost all girls in our society try to diet during adolescence. This probably relates to a factor of human development: With puberty, girls stop growing in height and accumulate extra fat tissue which is an important organ in the metabolism of their hormones. If they continue to increase their energy intake as they had throughout their childhood, they become plump. Young males experience puberty differently: with increasing levels of male sex hormone, their muscle bulk increases, and they need to eat more than they had as children. Of course, this biological difference is not all there is to the different ways in which girls and boys experience their bodies during and after puberty, and of course social and psychological biases are important in making issues of shape and weight assume a higher salience in young women than in young men. But it provides the basis for a biological explanation for the remarkable imbalance in the occurrence of eating disorders between the sexes.

Voluntary food restriction or dieting is just a preliminary. Although almost all girls diet, only some go on to develop a dieting disorder. The reason for their vulnerability requires explanation. A likely candidate is genetic vulnerability. There are at least 2 ways in which a genetic factor could exert an effect. It could determine the personality profile of the person who is most likely to be drawn into a vicious circle of dieting and reaction in a response to social and psychological pressures. Or it could affect the way the body responds to energy intake. The first line of enquiry has been adopted mainly by those seeking a genetic basis for anorexia and bulimia nervosa, with conflicting results to date: some authors suggest evidence of a common genetic factor in both, others claim a link between anorexia nervosa and obsessive compulsive disorder, but exclude bulimia. The second is the approach commonly taken in relation to obesity research: proposing a defect in a gene governing the uncoupling protein important in fat metabolism, or the gene governing the production of leptin or other hormones that regulate weight. But either approach is legitimate in either circumstance. What matters, is that a link is established that can be used to derive effective treatment.

An interesting corollary to this way of approaching the problem is that vulnerability to developing a dieting disorder may be equally distributed between the sexes. The reason why females predominate as sufferers may be simply that they are more likely to engage in the risk behaviour, viz food restriction, during adolescence.

Thus the physical-biological and the socio-psychological approaches may stimulate and direct each other towards a satisfactory comprehension of dieting disorders in general. Now let us address anorexia nervosa in particular.

Anorexia nervosa: an overview

Anorexia is not just, or perhaps not even primarily, an eating or dieting disorder, to be comprehended in social and biological terms. It is also a mental illness and a medical illness, warranting the same kind of scientific medical investigation as other physical and psychiatric illnesses. There are many questions about it that require explanation in scientific terms, rather than understanding in experiential terms.

Today, in developed countries such as Australia and New Zealand, anorexia nervosa is the most common serious disease of adolescent girls and young women. This is a big claim to make, but it can be justified.

How does one rate the seriousness of different diseases? Surely one needs to bear in mind how common the disease is, its mortality rate, persistent morbidity, chronicity, effect on the sufferer's life and on the family. On each of these criteria, anorexia nervosa is very severe. Although often dismissed as a rare illness, anorexia nervosa is actually highly prevalent when compared with other serious diseases in this population group. Point prevalence for girls in the age group 15-19 is 0.5%, and about half that in women aged 20-24. After obesity and asthma, it is the most common disease in this population group, and it is a much more deadly condition than either of the others. It is 10 times more common than IDDM in these subjects. Its prevalence rate of 0.5% in one age group should be compared with the lifetime risk of 1% of schizophrenia. In New South Wales at least 400 new cases are diagnosed each year, and about 5,000 patients are affected by anorexia nervosa at any one time.

The mortality rate on a number of follow-up studies is about 20% at 20 years. This is completely unacceptable for a disease whose sufferers have an average age at onset of 17 years. The overall mortality rate for anorexia nervosa is 5 times that of the same aged population in general, with deaths from natural causes being 4 times greater (eg cardiac arrhythmia, infection), and deaths from unnatural causes 11 times greater than expected. The risk of successful suicide is particularly high, being 32 times that expected. These figures may be compared with major depression, in which the overall mortality risk is 1.4 times that expected, with deaths from unnatural causes being seven times and those from suicide 20 times greater than expected.

Anorexia nervosa has a chronic course even in those who survive: the average duration of illness is 5 years. Even those who recover are unlikely to return to fully normal health, and women who have had anorexia nervosa often have anorexic daughters. The risk of a first degree relative of an affected person developing the disease is 10 times that of the general population. Many patients become chronic, and the disease brings about a degree of social handicap comparable to schizophrenia.

Persistent psychiatric morbidity is common, especially dysthymia, major depression and obsessive-compulsive disorder. The disease leads to brain atrophy and a disorder of myelination, and there is controversy about whether it has persistent effects on cognition. Certainly, because it usually occurs at the crucial stage in the girl's physical, psychological and social development, it causes serious impairment of functioning and interferes with education, work training, adaptation to peer relationships, sexual relationships and separation from the family of origin.

Cardiac arrhythmias are a common cause of sudden death in anorexia nervosa patients. Long-term physical morbidity is also common and serious. Growth retardation is present in some patients who have an early onset of disease. Anovular infertility is common in women who have only partially recovered. Terming this hypothalamic anovulation is misleading and dangerous, as it leads to medical intervention to induce pregnancy. This is unwise, as the pregnancies of such women are known to have more complications, result in more premature births, and to be associated with poor Apgar scores and underweight neonates. Osteopaenia leading to osteoporosis is a serious complication of the active disease, but may also have long-term effects because bone mineralization in women terminates with the menopause. Those who have not accumulated sufficient bone in younger life are prone to developing osteoporosis with ageing earlier than their peers.

More women die as a result of a fractured femur than of breast cancer. Renal and hepatic function are frequently permanently impaired by anorexia nervosa, and a neurogenic bowel with subsequent rectal prolapse is common, sometimes but not invariably associated with laxative abuse.

The effects of the disease on the family are horrendous. Unfortunately, parents have been blamed for causing the disease in their offspring. Anorexia nervosa is often claimed to result from sexual abuse, but this is less common than alleged. As a result, parents are made to feel guilty. The sick person imposes strain on all members and relationships within the family, leading to family dysfunction, marital discord and the relative neglect of siblings.

Clinical presentation

Anorexia nervosa is characterised by:

- Deliberate loss of weight
- Excessive fear of obesity and weight gain
- Associated physical dysfunctions

The key feature of anorexia nervosa is deliberate loss of weight, which is achieved by strict dieting and the avoidance of foods that are perceived to be fattening. Fasting continues despite excessive hunger and cravings for food, and subsequently in relation to confused perceptions regarding physiological signals of hunger, so that sufferers may lose the ability to know when they are hungry. In addition to the avoidance of 'fattening' foods, the following weight loss tactics may also be employed:

- Self-induced vomiting (sometimes with the assistance of emetics such as Ipecac)
- Self-induced purging (abuse of laxatives or high quantities of fibrous foods such as unprocessed bran or prunes)
- Excessive exercise
- Use of appetite suppressants
- Use of diuretics

Another key feature of anorexia nervosa is the excessive fear of obesity and weight gain. This fear persists as an intrusive, overvalued idea. Concerns about shape and weight have an exaggerated influence on self-image in general. Such concerns produce marked distress and dysfunction among people with dieting disorders. Consequently they set very low and unrealistic target weights for themselves and do not acknowledge that they have a problem with their weight or eating behaviours at least early in their illness. Later on they may acknowledge having problems in these areas but feel helpless about changing their fears or behaviours. These persons typically have low self-esteem and obsessional traits.

Anorexia nervosa also causes abnormalities of the endocrine systems which result from semi-starvation. In women the disorder manifests itself as amenorrhoea (cessation of menstruation for at least three months) although this symptom is obscured in those who are receiving hormone replacement therapy in the form of the contraceptive pill. In men the endocrine disorder is associated with a loss of sexual desire and potency. In both sexes, semi-starvation may also cause alterations in thyroid hormones and increases in the amount of stress steroids such as cortisol in the blood.

In pre-pubertal children, anorexia nervosa may be evident by the failure to make expected weight gains during the period of growth. Pubertal events, such as menstruation, breast development, maturation of male genitalia, are typically delayed although puberty is often completed normally after recovery.

Physical symptoms of anorexia nervosa

Some of the physical symptoms of anorexia nervosa are directly related to the effects of semi-starvation while other physical symptoms are mainly associated with behavioural problems such as excessive exercising, vomiting, or purging. Table 1 on the following page lists the most common physical symptoms.

From the clinical perspective, the most important of these symptoms are the biochemical and cardiac complications which may be life-threatening, and the osteoporosis which may be irreversible.

Psychological symptoms of anorexia nervosa

As with physical symptoms, psychological symptoms may be caused directly by starvation or may be independent and/or existing prior to the dieting disorder. The most common psychological symptoms are listed below.

Psychological symptoms caused or made worse by semi-starvation.

- Depression
- Loss of concentration
- Preoccupation with thoughts of food
- Anxiety
- Labile mood (i.e., fluctuating from one extreme to another)
- Irritability
- Feelings of inadequacy
- Hypersensitivity to noise
- Obsessional thinking
- Increased perfectionism
- Social withdrawal so as to avoid situations involving eating
- Depression/suicidal ideation
- Poor sleep quality (interrupted, fragmented, not restful)
- Compulsive behaviours

Table 1: Common physical symptoms of anorexia nervosa

Gastro-Intestinal and Urological	• Reduced gastric motility • Constipation due to lack of bulk in bowels and laxative abuse • Feelings of bloating • Abdominal pain and early satiety (feeling very full after little food due to shrunken stomach) • Polyuria (often due to diuretic effects of ketones produced in the body by starvation and by increased water consumption).
ENT	• Dental decay
Dermatological	• Swollen salivary glands, giving the face a square outline • Brittle hair or hair loss • Lanugo hair • Dry skin
Musculo-Skeletal	• Stunted growth • Brittle bones with inadequate amounts of calcium in the bones causes • Osteopenia and, more severely, osteoporosis in young women which is a result of • Low oestrogens (amenorrhoea), • High cortisol levels and • Dietary deficiency, often resulting in • Stress fractures in those who over-exercise or who otherwise sustain relatively small degrees of trauma to their skeletons
General	• Anaemia, iron deficiency and low white cell count • Disturbed blood chemistries primarily due to vomiting and laxative abuse • Oedema because of protein depletion • Hypothermia and sensitivity to cold and heat due to diminished layers of fat
Central and Autonomic Nervous Systems	• Fatigue, dizziness and tinnitus • Headaches • Hyperactivity
Cardiovascular System	• Bradycardia (pulse <60 bpm) • Hypotension • Excess variability in heart rate • Cardiac arrhythmias • Cardiac failure

Psychological symptoms that may be pre-existing or unrelated to semi-starvation

- Low self-esteem
- Obsessional traits
- A tendency towards perfectionism
- Symptoms of depression including low mood, feelings of guilt, feelings of helplessness and hopelessness
- Obsessional and compulsive traits
- Symptoms of anxiety including panic attacks

Abnormal eating-related behaviours

People with anorexia nervosa exhibit abnormal patterns of eating, and may also engage in unusual behaviours during meals. Some of these abnormal behaviours are listed in the following box. Keep in mind that not every person will exhibit all of these behaviours.

Abnormal eating-related behaviours include

- A refusal to eat
- Obsessional calorie counting or measurement of food quantities
- A reluctance to eat with other people and minimal conversation during meals
- Eating different food from the rest of the family
- Eating at different times from the rest of the family
- Leaving the table frequently during meals, especially to go to the bathroom
- Eating extremely slowly
- Cutting food into tiny pieces
- Pushing food around the plate or 'playing' with the food
- Secretly disposing of food during meals (e.g., feeding a pet under the table, wrapping food in a napkin, or putting food in pockets)
- Excessive water consumption
- Excessive use of condiments (eg, mustard)
- Unusual or inappropriate combinations of food
- Using inappropriate eating utensils
- Eating food in a specific sequence
- Fussiness about food or claiming to have a dislike of, or a 'reaction' to particular foods, especially red meat, sweets, and fatty foods
- Difficulty choosing what to eat
- Excessive interest in what other people are eating

- Feeling full after eating only a small amount of food
- Excessive use of diet foods (eg, low-fat or artificially sweetened)
- A desire to talk about food all the time
- Excessive handling of food and a desire to do the shopping and take over the preparation of meals

Anorexia nervosa is different from normal dieting in the following ways:

- Weight loss goals are unreasonably low for the person's shape and frame, and are constantly changing so that once one weight loss goal has been reached, a new, lower goal is set.
- The dieting behaviour is solitary. Most 'normal' dieters discuss their dieting progress and tactics with their peers. Determined, solitary dieting should be regarded warily.
- The patient is usually dissatisfied with success. Most dieters are pleased if they lose a few kilograms. Successful dieters who remain self-critical may be at risk.
- Menstruation becomes skimpier or ceases.

Diagnosis

The clinical features of anorexia nervosa are easily recognised and the diagnosis is usually made with high reliability between clinicians. All of the following signs and symptoms listed in the World Health Organization's (WHO) International Classification of Disease (ICD) 10th Edition are required for the diagnosis:

- The patient's body-mass index (BMI) is 17.5 or less, or body weight is maintained at least 15% below the expected or average body weight for the patient's age and sex. If prepubertal, the expected weight gain does not occur during the growth period. Calculation of the BMI is discussed below.
- Weight loss is self-induced and/or sustained through the avoidance of 'fattening' foods and through the utilisation of other weight loss tactics (as listed previously).
- Body-image distortion and a morbid dread of fatness is present such that the patient imposes an unhealthy and unreasonably low weight threshold on himself or herself.
- There is evidence of endocrine disorder in the form of amenorrhoea among women and loss of sexual desire and potency among men. There may also be elevated levels of growth hormone and cortisol, alterations to the metabolism of the thyroid hormone, and abnormal insulin secretion.
- In prepubertal patients, puberty is delayed but is often completed normally after recovery.

The Body-Mass Index (BMI)

A calculation of the BMI is the most convenient way to measure the extent to which a patient is underweight or overweight. The BMI can be calculated by dividing the patients weight by the square of his or her height, as indicated in the following formula.

$$\text{BMI} = \frac{\text{weight(kgs)}}{[\text{height(m)}]^2}$$

For adults, a healthy BMI is in the range of 20-25. A healthy BMI for adolescents is lower at about 18.5-25.

When weighing patients, keep the following points in mind:

- Use the same scales each time (preferably one with sliding weights along the top, as used in hospitals and gymnasiums since these scales are the most accurate).
- Ensure the scales are calibrated accurately at zero before use.
- Occasionally, some patients with anorexia nervosa may try to make themselves appear heavier than they really are by strapping weights close to their body or carrying heavy objects in their pockets or by drinking excessive amounts of water and avoiding urinating before weighing. If possible, for purposes of accurately comparing repeated weights, weight should be obtained at the same time each day, preferably in the morning, immediately after voiding.
- Excess clothing should be removed, such as coats, jumpers, scarves, shoes, belts, watches, and so on.

Differential diagnosis

In the absence of indicators of anorexia nervosa, the clinician may suspect a somatic cause of weight loss such as diabetes mellitus, hyperthyroidism, chronic infectious disease, carcinoma, a malabsorption syndrome, Crohn's disease or another chronic debilitating disease. However, it is not advisable to encourage extensive and invasive medical investigations if the patient's symptoms can be adequately explained by the diagnosis of anorexia nervosa.

People who are experiencing a major depressive episode may lose weight following the loss of appetite or motivation to eat. However, people with anorexia nervosa do not experience a loss of appetite; rather, they choose not to eat despite great hunger and desire for food (although they may deny being hungry if asked). Also, unlike people with anorexia nervosa, depressed people do not exhibit an excessive concern about their body shape or the caloric content of food, unless the depression is secondary to a diagnosis of anorexia nervosa or bulimia nervosa. Furthermore, unlike those who are depressed, people with anorexia nervosa will be pleased about their weight loss.

Obsessional symptoms (for example, fear of eating contaminated food, or decreased food intake due to the urge to chew each mouthful a specific number of times) may also account for weight loss. As always, a thorough psychiatric history will need to be taken prior to making a firm diagnosis. Psychotic disorders accompanied by delusions about food being poisoned may occur in schizophrenia, schizoaffective disorder, delusional disorder, or major depressive disorders with psychotic features, and may result in patients starving themselves for fear of being killed by what they ingest.

Anorexia nervosa needs to be distinguished from bulimia nervosa. In bulimia nervosa the patient alternates between episodes of food restriction and binge-eating (eating large amounts of food in a short period of time). This binge-eating is counteracted with compensatory weight loss behaviours such as vomiting, purging, excessive exercise, and further food restriction. People with bulimia nervosa are usually of normal weight or slightly overweight. However, if a patient displays bulimic behaviour when very underweight, only the diagnosis of anorexia nervosa (purging type) is made.

Epidemiology

Ninety to ninety-five percent of people with anorexia nervosa are female, and most are adolescents or young women. Children as young as eight years of age have also been known to develop this disorder. It has been calculated that there are approximately seven new cases of anorexia nervosa per year per 100,000 population, and probably as many as 120 people per 100,000 are suffering from the illness at any point in time. Anorexia nervosa is the third most common chronic condition in adolescent girls and young women, preceded only by obesity and asthma, and ten times as common as diabetes mellitus in this age group.

Course and prognosis

Approximately 70% of people with anorexia nervosa regain weight within about six months of intervention. However, 15-25% later relapse, and some eventually die from the disorder as a result of cardiac arrhythmias, opportunistic infections, suicide, or starvation, and approximately the same proportion remain chronically ill. Follow-up studies conducted four years after the onset of illness indicate that about 50% of people have an apparently good outcome (weight within normal range and a return of menstruation), 25% have an intermediate outcome, and 25% have a poor outcome. At 20 year follow-up, studies indicate a mortality rate of almost 20%, suggesting that most patients who retain chronic morbid preoccupations with food and weight go on to serious physical morbidity. Those people whose illness is less severe and who are treated as outpatients tend to have better outcomes although the chronic nature of the disorder makes long-term maintenance programs necessary for the prevention of relapse.

It has been estimated that mortality rates for anorexia nervosa may be as much as twelve times higher than for women of similar ages in the community and twice as high as for women with other psychiatric disorders. Among those people who are receiving outpatient treatment, a good prognosis is indicated by:

- an absence of severe emaciation (ie, body-mass index > 17)
- an absence of serious medical complications
- the motivation to change present behaviours
- the presence of supportive family and friends.

Poor prognosis is indicated by:

- the presence of vomiting in very malnourished patients, particularly vomiting that has become so frequent as to be almost automatic
- a later age of onset
- a history of neurotic and personality disturbances
- disturbed family relationships
- a longer duration of illness.

Generally, early recognition and intervention are highly desirable and are likely to lead to improved outcome. However, recovery is possible even after a long duration of illness and it is never too late to attempt vigorous treatment.

Staging severity and course of anorexia nervosa

Anorexia nervosa is a chronic disease which may vary markedly in severity. We need to distinguish between those who are more or less severely ill, as their overall management is very different. We also need to pay attention to prevention, early identification and intervention: hence, we must consider whether patients appear to be likely to develop the illness although they have not yet achieved the full gamut of diagnostic criteria.

The issue of course of illness is also important, but it is rather different from that of severity. It does dictate variations in management, in the setting of treatment, and in particular the need for a continuum of care. I believe the system proposed by the COST group in Europe is suitable. It is immediately obvious that several different parameters are necessary for staging severity (see Table 2).

Cumulative score

A multiaxial system by itself, as shown in Table 3, is too clumsy to be used for ready communication in practice. For that reason, I have assigned scores to each factor in such a way that they can be added to give an overall measure of severity, ranging from incipient, through diagnostic criteria equivalent to those of DSM-IV or ICD-10, to stages of moderately severe and very severe illness (see Table 4). The figures I assigned to the items in Table 4 were such that cut-off points of 20, 50 and 80, irrespective of the various combinations from which they could be derived, seemed appropriate for moderate, severe or very severe patients respectively.

Although precise semantic (or as DSM prefers to call them, operational) definitions are not given for the various items, the terms are in fact no less precise than those in DSM-IV.

Table 2: Parameters for staging of severity

1. Nutritional status	• Because of variations due to height, body weight itself is not appropriate. • Because of variations in normal body composition, neither body fat estimates nor BMI are really appropriate. • Because of variation of height to weight ratios during childhood, and because anorexia nervosa may cause stunting, prepubertal and young adolescent patients require a different form of nutritional estimation from adults. • Calculating percentage of normal or ideal weight is cumbersome and varies widely depending on the tables used: and setting figures for the ratio of height and weight percentiles in children is arbitrary. • Because of these difficulties, I decided that using the BMI in adults, and the BMI percentile in children, is probably the best and most convenient approach to the estimation of nutritional status.
2. Medical complications	• These may be present: associated with co-morbidity; serious; or life threatening.
3. Psychiatric	• Ranges from an exaggerated salience of weight, shape and fitness; through pervasive anorexic cognitions and serious psychiatric complications; to an irrational refusal of necessary treatment and overt suicidality.
4. Behavioural	• Both 'restricting' behaviours such as dieting and over-exercising, and 'purging' behaviours including vomiting, laxative abuse, and other potentially dangerous strategies, need to be recorded. And for both, a gradation of 'present' to 'frequent' is necessary.
5. Social	• Psycho-social disturbance needs to be noted, but unlike the other disturbances mentioned above, they are not crucial to the diagnosis.

Table 3: Axes for staging

	AXIS I: NUTRITIONAL (B.M.I.)	
	BMI	SCORE
	17.6-19.0	1
	16.0-17.5	5
	14.0-15.9	10
	12.0-13.9	15
	<12.0	20
	AXIS II: MEDICAL	
(a)	Medical complications (eg amenorrhoea) or nutritional deficiencies not requiring specific treatment.	5
(b)	As for (a) but with significant co-morbidity e.g. IDDM	
I	As for (a) and (b) but requiring specific treatment	10
(d)	Life-threatening complications	20
	AXIS III: PSYCHIATRIC	
(a)	Exaggerated salience of weight, shape and fitness	5
(b)	Pervasive anorexic cognitions or severe depressive and OCD symptoms	10
I	Irrational refusal of life-saving treatment or overt suicidality	15
	AXIS IV: RESTRICTION	
(a)	Restrictive eating and/or exercise and/or 'debts' exercise against eating	5
(b)	Almost complete food refusal (<500cals/day) and/or severe fluid restriction and/or obsessive exercising (unable to abstain for 24hours)	15
	AXIS V: PURGATION	
(a)	Vomits, purges or uses other dangerous weight-losing behaviours at least weekly	5
(b)	As for (a), but at least daily	15
	AXIS VI: SOCIAL	
(a)	Inappropriately over dependent for age; poor social contact with peers	5
(b)	Institutionalised at home or hospital, or socially isolated	15

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Table 4: Minimal criteria for diagnosis of anorexia nervosa: a score of at least 20 including a score of at least five on Axes I-III and on IV or V

I	BMI	5
II	Medical	5
III	Psychiatric	5
IV	Restriction	5
	or	
V	Purging	5
VI	Social	NA

Stage	Diagnosis	Total Score Required
Stage 0	Incipient Anorexia Nervosa	10-19
Stage 1	Moderate anorexia nervosa	20-49
Stage 2	Severe anorexia nervosa	50-79
Stage 3	Very severe anorexia nervosa	>80
Maximal Score	Axis I - 20 Axis II - 20 Axis III - 15 Axis IV - 15 Axis V - 15 Axis VI - 15	100

Course of illness

Dieting disorders affect patient's lives for a considerable period of time, often for many years. Not only is it necessary to define the features of these illnesses cross sectionally as the present at a certain time point, but it is also important to employ longitudinal outcome concepts such as the acute episode, partial and full remission, relapse, recovery and recurrence. A collaborative European group is currently devising a method of doing this in a standard way. The proposals are summarised in Tables 5 and 6.

Treatment of the illness: A doctor's perspective

Anorexia nervosa is extraordinarily expensive to treat. Because of the long duration of hospital admission and the frequency of relapse, anorexia nervosa patients occupy one-tenth as many hospital beds as do those with schizophrenia in New Zealand, and the same appears true of New South Wales. The Medical Benefits Fund, a major health insurance provider in Australia, has published figures showing that anorexia nervosa patients are consistently among those making the highest claims.

Despite the devastating nature of the disease, services for anorexia nervosa patients are inadequate. Until recently, the only specialized units in England and Wales were in the metropolitan London area, Leeds and Oxford, and the only specialized facility in Scotland was an outpatient service. In the USA, managed care is leading to the extreme restriction of treatment facilities for anorexia patients. In New Zealand, the whole of the South Island is serviced by a unit in Christchurch. In Toronto, funding cuts have led to the closure of an inpatient unit and its relocation as a day unit in a mental hospital. This has led to a raised mortality rate for anorexia nervosa in Ontario. In New South Wales, there are only about 20 public beds available for specialized care of anorexia nervosa, and this is in a State that has approximately 2,000 sufferers of the disease, with about 400 new cases each year. Patients who are privately insured have more facilities available, but these too have been severely restricted by providers of private mental health care in the State.

Because of step-downs in remuneration for long-stay patients, anorexia nervosa is not a financially rewarding condition to treat.

The only health authority that has reason to be proud of the facility it provides for anorexia nervosa is the province of British Columbia in Canada, where, under the leadership of Elliot Goldner and Laird Birmingham, a province-wide service has been established. However, it is under-funded.

Why is this devastating illness treated so poorly? Part blame must go to the bad press it usually receives from the popular media. Anorexia nervosa is either sensationalized or made into a silly girl's experience. The general public is also at fault. Slenderness is promoted as an ideal for beauty,

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Table 5: The cost proposal

Principles and Rationale for Consensus Definitions of Outcome

Principles	
1.	Outcomes are expressed in operationally defined terms based on observable, measurable phenomena
2.	Whether the outcome has been affected by treatment is irrelevant to the classification
3	The temporal focus is lifelong (limited by observation time) rather than episode specific. This allows a definitional scheme that could be applied to individuals with multiple episodes over a lifetime as well as to individuals who experience only a single episode.

Rationale	
Episode	Is a period, lasting longer than D days, during which the patient is consistently within the full symptomatic range on a sufficient number of symptoms to meet syndromal criteria for the disorder.
Partial Remission	Is a period during which an improvement of sufficient magnitude is observed that the individual is no longer fully symptomatic, but continues to evidence more than minimal symptoms.
Full Remission	Is a period (>E days but <F days) during which an improvement of sufficient magnitude is observed that the individual is asymptomatic (i.e. has no more than minimal symptoms).
Recovery	Is a full remission that lasts for F days or longer.
Relapse	Is a return of symptoms satisfying the full syndrome criteria for an episode that occurs during the periods of remission, but before recovery.
Recurrence	Is the appearance of a new episode of the disorder and thus, can occur only during a recovery.

Table 6

Longitudinal Concepts of Outcome Measures in Anorexia Nervosa

Restricting Subtype (AN-R)

Partial Remission AN-R	BMI > 17.5 kg/m2 for 1/12 No purges, vomiting or binges
Full Remission AN-R	BMI > 19.0 kg/m2 for 3/12 No purges, vomiting or binges No extreme anorexic attitudes
Recovery AN-R	As above, but for 12/12 or more
Relapse	BMI ≤ 17.5 kg/m2 for 1/12 If fall from full remission to full syndrome For 1/2
Recurrence	If fall from recovery to full syndrome for 1/12

Purge Subtype (AN-P)

Partial Remission AN-P	BMI > 17.5 kg/m2 for 1/12 Vomits or purges < once per week
Full Remission AN-P	BMI > 19.0 kg/m2 for 3/12 Neither vomits nor purges No extreme anorexic attitudes
Recovery AN-P	BMI > 19.0 kg/m2 for 12/12 No vomiting or laxatives for 12/12 No extreme anorexic attitudes
Relapse AN-P	If fall from full remission or partial remission to full syndrome for 1/12
Recurrence AN-P	If fall from recovery to full syndrome for more than 1/12

and beauty is given more prestige than any accomplishments that a woman may achieve. Anorexia nervosa is by no way a modern illness: it was first described in its present form in the mid-19th century, and earlier accounts can be found in the prior medical literature and in the accounts of the lives of some saints. It has fluctuated in epidemics that correspond to the level of social pressure applied to young women to diet, whether to be fashionably slim, or to suppress sexuality. However, a feminist perspective of these pressures needs to be viewed with caution. Anorexia nervosa is most common in those societies in which women have come closest to achieving equal rights, and there is an almost perfect opposition between countries with a high female illiteracy rate and those with a high prevalence of the disease.

The medical profession must assume some responsibility for this tragic circumstance, partly because of sins of omission, partly for sins of commission. Because it usually starts in adolescence, anorexia nervosa is considered an adolescent illness. For instance, in the DSM-III classification of the American Psychiatric Association, it was listed under disorders of adolescence. In fact, because of its chronic cause, patients most at risk are usually young or middle-aged women rather than adolescent girls. However, physicians by and large are poorly fnformed about the disease and not interested in treating its sufferers. Because

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of an erroneous assumption in Simmond's original description of panhypo-pituitarism (viz that it was associated with emaciation, which in fact was due to the presence in his population of some patients with tuberculosis or neoplasia), anorexia nervosa temporarily lost its importance for psychiatrists. They were replaced by endocrinologists, who undertook extensive but unnecessary laboratory investigations, but did little if anything about treatment.

Since its return to psychiatry, anorexia nervosa has been subjected to well-meaning but ultimately harmful reassessment. In 1979, a paper entitled: *Bulimia nervosa, an ominous variant of anorexia nervosa* was published by Gerald Russell, who had taken several years to collect the small number of patients that he described. Bulimia nervosa appears to have exploded shortly thereafter. Within a few years thousands of patients were seeking treatment for it. Habermas has argued convincingly that bulimia nervosa is an iatrogenic condition. Whether or not this be so, it has diverted attention from anorexia nervosa.

The medical care of anorexia nervosa is split between various branches of the medical profession, none assuming overall responsibility and each working according to different paradigms. In the younger age groups, treatment of the severely ill patient is usually in the hands of paediatricians and adolescent physicians, who with perhaps unjustifiable enthusiasm use naso-gastric feeding to effect nutritional restoration. Psychological treatment is usually relegated to child psychiatrists or other mental health workers, who often avoid assuming any responsibility for the patient's physical condition. For older sufferers, physicians usually decline involvement except to intervene in states of emergency, while psychiatrists often refuse to treat these patients, or treat them only on condition that they do not mention their main psychopathology, viz the extreme concern and guilt they feel about weight and eating.

Proponents of the view that psychiatry should concern itself more with caring for the seriously psychotically ill, and not be distracted by the 'worried-well', usually neglect any consideration for anorexia nervosa.

As a result, anorexia nervosa has become demedicalized. While previously those most concerned with its treatment were medically qualified, nowadays it is more likely that a psychologist, social worker or dietitian will be in charge of its management. Although these health professionals are well equipped to deal with less serious conditions such as bulimia nervosa and binge eating disorder, they do not have the training to recognize and treat the important physical manifestations of anorexia nervosa. Worse, the treatment of anorexia patients often passes to lay therapists, who are at best untrained, at worst charlatans.

Even the laws pertaining to the treatment of anorexia nervosa are uneven. They differ from country to country, and from state to state in the USA and Australia. Some authors claim that compulsory treatment is never indicated in anorexia nervosa, but offer no reasonable alternatives, and others have allowed anorexia nervosa patients to starve themselves to death without intervention. In the UK, about 11% of anorexia patients are treated following compulsory admission under the Mental Health Act. This is a less than satisfactory provision, as patients with anorexia nervosa pose completely different sorts of problems from those usually dealt with under these laws, ie. those with psychotic illness. In NSW, anorexia nervosa was excluded from the Mental Health Act of 1990, and the issue of compulsory treatment is dealt with under the Guardianship Act of 1987. Unfortunately, the Guardianship Act was not amended to empower the guardian to take the sorts of decisions that are necessary for these patients. For instance, the public guardian in NSW decided that cognitive-behavioural therapy is a psychological matter rather than a medical treatment, and refused to endorse its use in anorexia nervosa. Because of difficulties of this kind, and the need to undertake urgent medical procedures, a precedent has been set to schedule anorexia nervosa patients under the Mental Health Act in appropriate circumstances.

Even those doctors who have interested themselves in research into anorexia nervosa have done their patients little service. Many academic careers have been based on a thorough exploration of endocrine dysfunction in anorexia patients, but it is now clear that the endocrine manifestations are epi-phenomena, not relevant to the cause of the illness. A great deal of research effort has been wasted on the concept of a distortion of body image in anorexia nervosa, with little of use resulting to the patient. More recent work on taste discrimination, genetics, cognitive functioning, body composition, energy utilization, and the newly discovered hormone leptin, do not appear to be leading to significant treatment advances, and are of academic more than of practical interest. In contrast to bulimia nervosa, there is an alarming paucity of evidence-based medicine relating to anorexia nervosa.

Principles of treatment

Accepting a medical and psychiatric perspective on treating anorexia nervosa implies the use of similar value systems, scientific explanations and evidence-based interventions as in the rest of medicine.

Values

1. The anorexia patient has the same right to treatment as do patients with any other disease. They should not be denied this because their illness can be considered as self-inflicted. In our society, most illnesses are self-inflicted, to some or other extent. Malignant melanoma results from incautious exposure to the sun; cardio-vascular disease is commonly associated with overindulgence in food; emphysema, lung cancer, and other neoplasia, result from cigarette smoking, HIV AIDS – the list goes on and on. Where the anorexia nervosa patient perhaps differs from the others is that the risk-taking behaviour persists

throughout the illness: if only the patient would change her behaviour, she would recover. But it is not that simple. Once embarked on a course of illness, it is very difficult to abandon it. There is something about the nature of being anorexic which is resistant to change. Why that is so needs explanation, just as it was necessary to accept that nicotine is an extremely addictive drug before effective measures could be developed to help people give up cigarette smoking. What is it that makes anorexic behaviour so addictive?

2. Because anorexia nervosa sufferers have a right to treatment, they should receive the same sympathy and courtesy as other patients. A health professional has no more right to decline involvement with this illness than with any other. If the professional feels incompetent in treating anorexia patients, he or she should seek out ways to gain that competence. Medical educationalists need to teach students about anorexia nervosa in the same way as they teach about other illnesses. The patient and her carers have a right to expect both sympathy and skill from their medical advisers in dealing with this illness.
3. It follows that issues of access are very important. At present, expertise (such as it is) is largely restricted to specialized centres: what is needed is a periphery of excellence, with ease of access to all who need it, and with the provision of information as to when medical help should be sought, and where to go for it.
4. The severely ill anorexia nervosa patient is often patently irrational in her denial of illness, or at least her refusal of treatment. The question arises: to what extent should she be protected from herself? As with other mental illnesses, there is a conflict between the preservation of the patient's human rights, and her right to receive the treatment that she needs. The two ways that this conflict usually intrudes are:
   - (a) The question of confidentiality. Patients in extreme physical danger because of their anorexia nervosa often refuse doctors permission to contact their relatives or friends. However, the doctor should use discretion in deciding whether or not to accept this limitation in just the same way as when judging what to do about suicidal intent;
   - (b) Involuntary treatment is sometimes necessary. As with all psychiatric illnesses, optimal practice is to use as little restriction or coercion as possible. But the duty of care overrides this principle in times of extremity.
5. Resources should be devoted to anorexia nervosa treatment and research in direct proportion to its importance as a health problem. Unfortunately, this is not done, perhaps because it has not received strong advocacy from health professionals or in the community. The reasons for this, and ways to overcome the problem, need to be addressed.

Scientific explanations: symptoms as the result of the disturbed behaviour

Although the aetiology of anorexia nervosa remains unclear, much is now known about the progress of the disease once it is established. After decades of research directed at finding an underlying physical cause, it is now generally accepted that all the physical features of the illness are secondary, the result of emaciation and the behaviours used to induce it. This does not diminish its medical importance. Rather, it imposes the obligation on the doctor to understand the effects of undernutrition and the dangers that arise in its reversal (the refeeding syndrome). The doctor must also be aware of the chronic and often irreversible consequences of the illness, understand how they develop, how they may be prevented, and how treated.

Many of the psychiatric features of the illness are also secondary to the process of the disease. The psychiatric effects of prolonged food restriction in healthy volunteers are known to lead to a decreased sexual libido, depression and increasing obsessionality. As the state of nutrition deteriorates, anatomical changes occur in the brain. Atrophy is discerned in the enlargement of the cortical sulci and expansion of the ventricular spaces, and demyelinization is prominent.

Psychiatric dysfunction results from these organic changes, and also psychogenetically from the patient's feelings of disempowerment and hopelessness, and increasing isolation from peers and family.

Medical and psychiatric interventions

There is general consensus about the treatment of the acute anorexic episode. First, the medical complications need to be assessed, and where necessary addressed. Abnormalities such as the down regulation of thyroid hormone and the disturbed reproductive function are best considered as compensatory mechanisms to cope with the undernutrition, and their reversal is not indicated. However, other complications, such as the disturbance to blood electrolytes, cardiac compromise, or hypothermia, require urgent correction. Second, the nutritional state needs to be restored, preferably by encouraging the patient to take a healthy normal diet with supplementation of some essential nutrients such as thiamine. If this co-operation cannot be achieved the use of special, energy-rich liquid diets may be employed, or if necessary nasogastric feeding. An operant conditioning behavioural program may also be indicated, but if so this should be of a lenient and flexible nature, with minimal restraint.

Simultaneously, treatment of the psychiatric disorder is required. Various forms of psychotherapy are advised, particularly cognitive therapy, aimed at correcting faulty beliefs about food and weight, and also at changing the characteristic ascetic, self-punitive and self-denying value system from which the behaviours derive. Psychotropic medication is directed at the symptoms of depression and obsessionality, and also to decrease the hyperactivity and restlessness which are often prominent.

Both physical and psychological treatments need to be administered in a setting in which the patient's behaviour can be supervised. Firm boundaries need to be laid down, and at the same time reassurance, sympathy and encouragement need to be given. Dedicated and skilled nursing staff and dietitians are invaluable in their day-to-day contact with patients. The treatment setting is often provided in a specialist in-patient ward, but the same effects can be achieved in a comprehensive and well-structured day program, or as an out-patient when there is a supportive home background and relatives or friends who are willing to work as co-therapists.

Case Study: Treating the chronic patient

> *Cindy was a 40 year-old female with anorexia nervosa, who I had followed for 20 years, until her death. She had severe unremitting restrictive anorexia nervosa complicated by hyponatremia, hypokalemia, hypomagnesemia, an empyema of her lung, multiple bone fractures, renal failure, anaemia, and terminally, pneumonia and acute inferior myocardial infarction. Cindy had been admitted repeatedly over the years to various dieting disorder units, she had tried and given up on the many psychiatrists and psychologists she had seen, was on chronic disability from her work, and within the last few years of her death moved to an apartment in a suburb where she would eat very small amounts of food and have intermittent infusions of saline, potassium, and magnesium at home. Cindy had been emaciated for years, but enjoyed helping others and always asked me about my children and would send them birthday presents. Although she could hardly hobble around with the use of a cane, she dressed in vividly coloured glasses and maintained her dignity to the end* (Laird Birmingham).

The treatment of patients with chronic anorexia nervosa is widely misunderstood. As in many illnesses, the rate of recovery is variable. The average patient with anorexia nervosa may have the disorder for a few years, but many patients will continue to be anorexic for many years and some for life. Many physicians become confused when it appears that treatment does not work and adopt a palliative care approach to the treatment of patients with chronic anorexia nervosa. This is tantamount to treating someone with asthma palliatively.

A full understanding of this perspective results in the following conclusions in chronic anorexia nervosa:

1. Treatment of intercurrent medical and psychiatric conditions is still indicated.
2. The treatment of malnutrition continues limited only by a continuing risk-benefit trade-off.
3. Focus on improved quality of life through rehabilitation.
4. Finally, as in asthma, anorexia nervosa may remit at any time in its course.

Clinical remission in chronic anorexia nervosa usually occurs due to sociological change (eg divorce, death of a parent, decision to change careers) or because the patient simply becomes tired of being burdened with anorexia nervosa.

All patients with anorexia nervosa can recover, and some recover decades into their illness. However, while the patient continues to suffer from chronic anorexia nervosa, the important mode of treatment is a rehabilitation model.

Patients with chronic anorexia nervosa have ongoing signs and symptoms of protein-calorie malnutrition. They will have thinning of their hair, dry and yellow skin, decreased ability to focus their eyes, shortness of breath on exertion, decreased exercise capacity, repeated dysrhythmias, dizziness on standing, weakness, tiredness, hypothermia, muscle cramps, and decreased memory and concentration. As well, they will suffer from progressive osteopenia which will cause repeated fractures which start off as stress fractures and later become symptomatic fractures of the spine and lower extremities.

Chronic anorexia nervosa is associated with social isolation, an inability to work and learn, and diminishment of functional activity including with family, friends, and work. Depending upon the level of debilitation of the patient, they may be a recluse in a small apartment isolated from their family or they may be a thin patient with significant weight and shape concerns who is fully integrated into their family, work, and society. Clearly the rehabilitation goal is to move a patient with anorexia nervosa from the former to the latter situation.

The overall goals in following a patient with anorexia are:

1. To prevent death by monitoring depression, actively preventing suicide, building rapport, searching for psychological co-morbidity which might prevent improvement or diminish quality of life, helping set goals for rehabilitation and continuing to celebrate life with the patient (at every visit).
2. Medically, the frequency of follow-up varies, depending upon the degree of illness, from every week to every three months. The weight, blood pressure, and heart rate should be taken. An inquiry regarding mood and plans should be taken with goals established. If the patient is losing or gaining weight, potassium, magnesium and phosphate should be measured. If the weight is unchanged this is not necessary. If there is significant deterioration in physical symptoms, a systemic inquiry and physical examination with laboratory measures is necessary, selected based on symptoms (often to include: haemoglobin, electrolytes, creatinine, AST, alkaline phosphatase, magnesium phosphate, B12 and ferritin).

The physician should concentrate first on physical complaints. Chronic anorexia sufferers find it much easier to talk about physical concerns. Treatment of physical problems is easily accepted, appreciated, and this increases rapport. Treatment of urinary incontinence (which commonly occurs in chronic anorexia nervosa), careful care of feet and toes, and prevention of osteopenia with calcium and vitamin D supplements, should all be considered. Use of the birth control pill to continue menstruation and potentially to increase bone mass should be discussed. In my opinion this is a two-edged sword as medication treatment of osteopenia may be taken as a reason to focus less on re-nutrition.

Psychologically, the focus should be on rehabilitation and quality of life. Any co-morbid condition such as a history of sexual abuse, substance abuse, or depression should be sought and may require long-term treatment before other psychological gains are possible. If motivational enhancement therapy is available, patients should be encouraged to undertake it. The primary physician should use a narrative approach in most cases. This focuses on discussing the patient's life not according to their daily miseries, but in the context of how someone would want to retell their story. The narrative approach should focus in particular on how their life could be improved to make the story more to the patient's liking. Often it is useful to refocus the patient on their life by pretending it were a movie and changing the ending or episodes of the movie as they would if they were directing it.

One must be very careful regarding the involvement of the family in the treatment of chronic anorexia nervosa. There are often powerful feelings of guilt and anger that other family members hold towards the anorexia sufferer. As well, the sufferer may be ostracised from their family. Therefore, any discussions with family members are best done at the patient's request and with the patient present. As a primary physician, these often are in the form of family interventions. For example, the patient may wish to change their place of residence, apply for disability insurance, or discuss their place in the family. A physician can act as a mediator for the patient and explain the patient's disease in the context of a process for which chronic rehabilitation is necessary. It is of immense importance that the primary physician respects the right of privacy of the patient. This is particularly difficult in the setting of a family physician who has treated the entire family for years. It is my practice, and advice, that all patients who reach the age of majority be treated as independent adults, regardless of their health or place of residence. All parties, the patient, their family, and other hospital staff, must be aware of this policy or patient confidentiality will likely be breached and the patient's trust lost forever.

Evidence-based medicine

Despite general consensus about acute treatment, there is little evidence-based literature to support current practices. Some, such as the reversal of serious medical complications, appear obvious. But others are perhaps less easy to support. Among the issues that require scientific study are the following:

(1) Is it better to restore nutritional state rapidly (for instance by nasogastric tube feeding) and then normalize eating behaviour? Or should one seek to normalize nutrition by normalizing eating from the start?

(2) Is rapid refeeding preferable, or less valuable, than gradual refeeding?

(3) Is it necessary to restore the patient to a normal state of nutrition while in acute treatment, or merely to get her back to a safe weight? And if the former, is normal nutrition rightly assessed as being within the normal weight range, or does it mean a return to premorbid weight?

(4) Anorexia patients selectively avoid high-energy, fatty foods. Should weight restoration on a predominantly carbohydrate diet be condoned, or should the patient be pushed to include normal proportions of fats and proteins?

(5) Do psychotropic drugs exert any beneficial effect on the course of anorexia nervosa? Are they effective against the secondary psychiatric symptoms, eg antidepressants effective against depressive symptoms in the context of the illness? Or against obsessive-compulsive symptoms? (There have been no trials directed at this specific issue)

(6) Is psychotherapy beneficial? And if so, is there anything specific about the psychotherapy, or is it simply the support it provides? Cognitive therapy is generally chosen, but is there evidence that it actually works in anorexia (as it does in bulimia nervosa)? What of insight-orientated or interpersonal psychotherapy or family therapy?

It is deplorable that so many relatively simple questions relating to the treatment of anorexia nervosa have not yet been subjected to experimental study. The few facts that have emerged are:

(a) that lenient and flexible behavioural programs are no less effective than strict approaches;

(b) that frequency of weighing does not appear to have an influence and that short-term behavioural programs are usually perceived by patients as helpful, albeit boring; and

(c) that family therapy is preferable to individual psychotherapy in younger patients.

Specific recommendations

What is to be done to correct the situation? First, the general public and the professions need to be educated about how serious and common an illness anorexia nervosa really is. Extreme weight-losing activities should be acknowledged as dangerous risk-taking behaviour, similar to the abuse of narcotic drugs, unprotected sex, and drink-driving. Second, doctors need to assume responsibility for this disease, which threatens the lives, future health and happiness of young and vulnerable people. Third, all doctors must know how to recognize and take appropriate action with patients presenting with anorexia nervosa. Secondary prevention may be successful, whereas primary prevention, on which much money has been spent, appears to be ineffective or even counter-productive. Fourth, the treatment of anorexia nervosa patients should be shifted from so-called centres of excellence to a periphery of excellence that includes community health clinics, day-hospital units, and a collaborative, shared care program with general practitioners. Fifth, State medical services need to include an integrated service with ready access for all patients requiring treatment. Sixth, research should be directed at discovering treatments that really work and better means of implementing them, such as through the present NSW Eating Disorder GP Shared Care program: The outcome of patients treated even by the experts of today is appalling. The outcome should be judged in more sophisticated terms than those measured by existing measures, and issues such as nutritional state and quality of life should be included. Seventh, until such evidence-based studies are available, clinical practice guidelines should be drawn up by authoritative clinicians with contributions from all legitimate stake-holders, including general practitioners, physicians, paediatricians, psychologists, nurses, dietitians and, importantly, consumers and carers. These have now been commissioned by the Royal Australian and New Zealand College of Psychiatrists. Eighth, a consistent decision needs to be made about the laws relating to anorexia nervosa that steers a middle path between excessive compulsion and the medical neglect of failing to protect a psychiatrically disturbed patient from the effects of her illness. Preferably, this legislation should be different from that providing for the needs of psychotic patients. Ninth, government authorities should take action against those who promote unhealthy messages about weight control, such as magazines that present pictures of emaciated girls, or even computer-modified pictures to exaggerate their extreme thinness, as a fashion idea.

Conclusion

If one looks at anorexia nervosa as a topic in the history of medicine, certain similarities with other diseases may be discerned. A particularly illustrative comparison may be made with tuberculosis.

The early medical literature describes some patients in whom tuberculosis, others in whom anorexia nervosa was probably the correct diagnosis, although the true nature of neither illness was realised at the time. In fact, the two illnesses resembled each other in aspects of their clinical presentation, and sometimes were confused with each other (as in Richard Morton's [1637-1698] Phthysiologia in which both anorexia and tuberculosis were described). Both were characterised by wasting (hence the Greek term 'phthysis' and the English 'consumption' for both). The famous description by Aretaeus of Cappadocia of a tuberculosis patient might as easily have been one of a girl with anorexia nervosa:

> *...severe wasting of the fleshy parts of the body leaving the bone prominently outlined; the nails crooked or flat and brittle without their normal rotundity....The nose sharp and slender, cheeks prominent and abnormally flushed; the eyes deeply sunk in their hollows but brilliant and glittering ... the jaws resting on the teeth as if smiling, but it is the smile of a cadaver ... not only may one count the ribs, but trace them to their terminations ... the shoulder blades are like the wings of a bird ...*

Both illnesses tend to occur in adolescents and young adults; from neither are the affluent and wealthy protected. Both have an ambience of mystery and romance: the tragic deaths of young and gifted persons (Keats; Mimi in La Boheme; the Best Little Girl in the World). Both showed subtle changes over the years, and fluctuated in their prevalence. And both have bewildered generations of doctors, and given rise to bizarre attempts at treatment whose only common features are their expense, their long duration, and their inefficacy.

Until recently, the tuberculosis patient who could afford the expense was withdrawn from his work, school or university to be sent to a sanatorium where he was fed a nutritious diet and exposed to the sun, as described in Mann's *The Magic Mountain*. Some returned 'cured', but many did not. The majority went on to chronic illness and early death. Time and again, the illness seemed to be conquered, but always it re-emerged. Even the advent of a truly scientific theory, discovery of the causative organism, and eventually the recent introduction of effective chemotherapy, may not have eradicated the problem. It is still a major disease of the Third World, and may again emerge in the West, because of the emergence of resistant strains of the mycobacterium and because of the opening for opportunistic infections provided by HIV-AIDS.

Not only is tuberculosis a common form of serious disease, but its effects on society have been great – beyond its immediate victims and their relatives and friends. Its association with childhood and innocence and even holiness gave it a romantic aura, expressed perhaps in the line *Half in love with easeful death*. It was a disease that forced doctors to question the purpose of their work.

Exactly the same is true of anorexia nervosa. The anorexia patient is portrayed as the young and innocent victim of an unjust society. Her resistance to treatment raises either antagonism, or a sense of awe and admiration. The illness defies reason. Its victims assume heroic proportions, and become *causes celebres* in the lay press. Doctors and other health professionals are baffled, and react to their frustrations with theories and treatments that are bizarre and unproven.

For a physician, neither tuberculosis nor anorexia nervosa should be special. They are diseases like other diseases – disgusting in their effects, and in no way glamorous. But both are powerful scourges of humanity. Perhaps, and only perhaps, we have found out how to treat and cure tuberculosis so that eventually it will be eradicated from the world. As yet, we have done nothing to contain anorexia nervosa. To describe the illness as a modern epidemic is an exaggeration. But it is an important and significant clinical problem, and warrants much scientific work to establish a basis for its effective treatment and prevention.

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Chapter 11 – Developing Motivation for Change in Individuals with Eating Disorders

Kelly Bemis-Vitousek

This Chapter has been adapted from a Keynote address presented at the: *Challenge the Body Culture – Attitudes, Acceptance and Diversity into the 21st Century Conference*. Brisbane, 1997. A significant proportion of the material was drawn from an article in press at the time: K. Vitousek, S. Watson & G.T. Wilson. Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review*.

Anorexia nervosa is widely considered one of the most frustrating forms of psychopathology for those who view it from outside. Few disorders evoke stronger reactions from professionals. Substance abuse probably comes closest, in that patients with either disorder are seen as denying, deceiving, and rationalising to protect the destructive symptoms they have brought on themselves. Those of us around them suffer, try to impose our will, grow angry, give in, or give up – often all of these in turn as each tactic fails and we become increasingly aware of our helplessless.

However, substance abuse can appear less bewildering and less infuriating to observers. Alcoholism is more widespread, has a longer cultural history, and is therefore more familiar. It involves the misuse of an addictive drug that most of us concede can be very difficult for some people to quit. Moreover, society allows family members or professionals, to leave alcoholics alone if they have repeatedly tried and failed to help them. However anorexia is less well understood, and we cannot withdraw from it, since neither our consciences nor society condones the abandonment of apparently sane young women who seem to be killing themselves before our eyes. We want to do something, we often feel mandated to do something, but we cannot. Furthermore, we are seldom thanked for our efforts to intervene by those we are trying to help and, for those in the 'helping professions', this lack of appreciation from those we seek to benefit can appear unforgivable. Anorexic individuals rarely seek treatment voluntarily. Even if they do show up in therapists' offices of their own accord, they are virtually never asking for assistance in gaining weight. They are more likely to be seeking help in coping with side effects or other issues they do recognise as problematic. They are typically cajoled or coerced into treatment by family, friends, or employers and the first line of defense, quite understandably, is usually denial.

The terms 'denial' and 'resistance' need not carry any psychodynamic significance in anorexia nervosa, for they are quite straightforward. Anorexic individuals may deny that they are ill, deny that they are thin, deny that they want to be thin, and deny that they are afraid of gaining weight. They may also refuse to acknowledge that they are distressed, fatigued, or that they are engaging in specific behaviours such as dietary rituals, vomiting, or laxative abuse. Some insist that each symptom that serves weight loss has an independent and completely benign meaning such as:

Well, I don't eat meat for ethical reasons ...

I don't eat butter because it's bad for your health...

I don't use vegetable oil because I don't like its slimy texture...

I don't eat sugar because I'm allergic to it...

I don't eat much at any one time because I hate to feel stuffed...

I exercise three hours a day because it relieves tension...

You are asking me why I lost 30 pounds? I didn't mean to, it just happened.

Are these patients deliberately lying? Not always, and not exactly, for as one former anorexic wrote: *I was becoming a master of excuses.... The quick lies were coming so automatically now that one part of my mind began to believe them* (Johnston, 1993, p. 31). Patients can be so successful in convincing themselves of what they wish to be the case that the claimed food aversions and lack of appetite become, in part, true. Others will acknowledge candidly that they did indeed intend to lose weight, while defending this decision as rational, correct, and most of all, their own business and not yours.

If anorexic individuals do remain in treatment (for whatever reasons), the second line of defense may be a subversion of any part of treatment that entails doing rather than talking. They may manipulate their apparent weight (by water loading or concealing heavy objects under their clothing), and may dispose of food surreptitiously (by hiding it in napkins or purses or feeding it to the family dog). In particular, they become skilled in distracting therapeutic attention away from the food and weight issues that are most threatening. People simply do not work so hard to preserve something they don't regard as valuable, perhaps essential, to retain. How should we understand this fierce defense of such a devastating way of life? The first part of the explanation is that the core symptoms of anorexia nervosa are egosyntonic. Unlike the symptoms of depressed patients, or those with a panic disorder, or obsessive-compulsive behaviours, anorexic symptoms are not experienced (at least initially) as alien or unwelcome, but as part of the self.

The behaviours of food restriction and excessive exercise are fully consonant with the goals of thinness and self-control (Fairburn & Wilson, 1997). In this sense, anorexic individuals are doing what they mean to do, and doing it effectively. Thus, as another former anorexic wrote: *The question of recovery is at best an irrelevance, and at worst an unmerited attack upon her integrity* (MacLeod, 1982, p. 100). The mother of one patient said to me: *When she is offered help in getting better, my daughter acts like a fish being thrown a life jacket, she is offended by the gesture, because she thinks she's swimming along just fine.* (Her daughter didn't really think all was well, of course, as quickly became clear – but the mother was quite correct that her daughter did not see weight gain as any part of the solution to those problems she did recognise).

This defensiveness again sounds like alcoholism, but it is not analogous. In fact, the egosyntonic pursuit of symptoms distinguishes anorexics even from the substance abusers who rival their reputation as unmotivated clients. Drinkers often protest that people are wrong to label them as alcoholic, but they seldom contend that alcoholism itself is a virtue. Their denial is person-specific and along the lines of: *Of course it would be a bad thing if I were alcoholic – it's just that you've made a mistake in thinking I could be one of those people.* In contrast, anorexics may experience pride in being recognised as discrepant from 'average' individuals who struggle ineffectually with weight control. They may see themselves as extraordinary rather than abnormal. One could question where they would get the idea that it is admirable to succeed in dietary restriction and extreme thinness. It cannot be denied that a portion of the answer must refer to the contemporary shared social meaning of these behaviours. Dieting and thinness are not just egosyntonic, but culturally syntonic (Frankenberg, Garfinkel, & Garner, 1982).

Eating disorder specialists can attest that jokes about anorexia are common. There is no equivalent in any other form of psychopathology. Therapists who specialize in schizophrenia are not subjected to hearing others exclaim: *Gosh, I wish I could be schizophrenic.* No one makes social chitchat like: *Oh, you work with panic disorder? Could you possibly teach me to have that problem?* This disorder is truly different.

There are a number of essential images and issues about the eating disorders that are especially salient, particularly among the media messages. Beginning in the mid-1960s and continuing to the present, we have been immersed in the same images and ideas. Beliefs about the importance and desirability of thinness are not eccentric or far-fetched. In fact, being clinically anorexic can be quite profitable, such as labels of 'skin and bones' as displayed in advertisements, can win multi-million dollar modeling contracts. People affected by eating disorders are not making these things up. The message that we would all benefit from weight loss is used to sell not only diet products, but also cigarettes and even picnic coolers.

Increasingly, women are placed in double-bind situations, asked to conform simultaneously to irreconcilable demands such as 'be very thin and very sexual' when these two qualities literally cannot be combined for they imply that one needs to be 'very thin, very sexual, very high-achieving, and very traditionally feminine'. The media images can often impose a specific double meaning about the eating disorders themselves. For example, the title page of a magazine article intended to update the readership on anorexia nervosa and bulimia nervosa may contain the usual material about body image distortion and the tragic consequences of pursuing the thin ideal. On the facing page of this same magazine, presented with no apparent irony, there may be an advertisement proclaiming that 'now you can have the body you've always wanted' (with the help of an expensive scrub brush and tube of gel with which you can rub away your fat).

Another item from the popular press, *People Magazine*, has two standard stories in this area that it regularly repeats: A feature on the year's *'Diet Winners and Sinners'*, and, at more spaced intervals, an article warning us about *'Famous Models, Dangerous Diets'*. The editors never seemed to notice any sort of conflict, even when they recently made the double bind itself the lead story *'Too fat? Too thin? How media images teach kids to hate their bodies....'*. Another double-bind that cannot be overemphasized in any forum is the celebration of the pre-pubertal female body type, when girls enter into the adolescent phase during which they will naturally, normally, and inevitably lose that child-like shape. This image is more disturbing in its implications and as illustrated by the cover of New York Magazine from 17 years ago. It was a feature on *'The Hottest Models in Town'* and it states: *'Cathleen is 13, Kristine is 12, and Lena is 15'.* I have shown this image to lay audiences with a request that they imagine it as the cover of a fashion magazine for men and to picture three adolescent boys depicted under the headings: *'The Hottest Male Models in Town: Steve is 13, Michael is 12, and David is 15'.* The audience always laughs, and considers that image seems hilarious, while the real version did not. Clearly, it may be because, at some level, it is accepted that our culture considers it plausible to show 'little girls to women' as exemplars of how they should appear. However, it is ludicrous to think that little boys could ever represent an ideal of masculinity for adult males. The bizarre custom of using child models to sell products to women continues to the present. The result is that all young girls see thinness so much that they become conditioned to want it, and as in the words of another 18-year-old, *People like Cindy Crawford are overweight.*

The other side of our collective pursuit of thinness is a horror and loathing of fatness. We have the sense that obesity is lurking out there to get all of us if we relax our vigilance. The general public health principle that Rose (1992) described as the 'iceberg phenomenon' does apply to the eating disorders. The size of that portion of an iceberg that sticks up above the waterline is a function of its total mass. The more drinkers there are in a society, the more alcoholics there will be, the more dieters, the higher the frequency of clinical eating disorders. Rose cautions that we cannot understand or control the visible tip of the iceberg if we think of it as the entire problem. We cannot eliminate the eating disorders by cutting off the top of the iceberg, but must work on melting down the whole.

This is a recognisable concern, but what can provide more effective help to those who are already suffering most acutely? We have to recognise the power of the social context while simultaneously understanding that the eating disorders are in no sense reducible to concerns about physical appearance. Bulimia nervosa did not exist until there were specific cultural pressures on women to control their weight, but anorexia nervosa did occur in the absence of such pressures (although it affected fewer women). However they start, both disorders clearly acquire much deeper connotations over time, and come to serve a wide array of adaptive functions – and the mix seems to differ from person to person. Some of these adaptive functions are defensive, protecting the individual from developmental pressures for independence, maturity, and sexuality; others are positively valenced, conveying a sense of competence, self-control, and moral purity. Some bridge both positive and negative reinforcement: The disorders can serve organising and simplifying functions for individuals who have difficulty coping with complexity and uncertainty.

It is difficult to get at the sense of elevation and distinction that some (but not all) anorexics associate with their disorder. One of the best descriptions of that experience does not come from an anorexic woman, but from a man who probably never met diagnostic criteria for the disorder, but seems to have lived through a period where he was familiar with its essence. This is a quote from John Leonard, a well-known journalist and columnist in the United States. In this passage, he is describing how he reacted when he went on a diet to drop weight he had gained after quitting smoking. It is a marvelous description of the odd, lofty, and compelling sense of virtue and refinement that anorexics can derive from restriction and weight loss:

> *In six months I lost 40 pounds, my sweet tooth, and my will to live. Living was much less interesting than dieting. I spent hours in the bathroom on the scales. Mine was the ecstasy of self-denial; rid of the sin of flab, honed down to a tuning fork of bone, I would, if struck, give off a pitch so perfect that matter itself would shatter and atoms disperse on winds of light. All that was opaque would be transparent. I am better now, thank you* (Leonard, 1978).

Anorexic patients may be even more protective of the 'ecstatic' aspects of their eating disorder experience than of its defensive functions – and perhaps in part for that reason, therapists tend to shy away from discussing these effects. These effects are present and powerful for many anorexic individuals, and addressing them must be part of the resolution of the disorder. In fact, as Ruth Striegel-Moore (1995) observed, the very appeal of thinness for women resides in the multiple meanings it conveys.

Yet denial and resistance are not entirely willful or deliberate, they are partly automatic and unmotivated. Patients may be unaware of the contingencies that support their behaviour. They are conditioned by their own experience to be relieved by weight loss and distressed by eating and weight gain even if they no longer wish to keep going. Starvation makes it difficult for them to appraise their condition rationally or shift to other patterns of thought and behaviour. As in other disorders, depression and demoralization induce pessimism about the possibility of living differently. The balance of these elements appears to shift over the course of illness. In the early 'euphoric' phase, most identify with their symptoms but after years of struggle, they may persist through helplessness and fear of change. At every stage, some degree of ambivalence is probably universal.

Individuals with bulimia nervosa are much more likely to share the clinician's agenda for change and are also more likely to fulfill it. The central issue of motivation for change differentiates these two populations as much as any other. They typically enter treatment through different routes. When I explored the basis for getting into therapy in one study, 92% of bulimics said that seeking help was entirely their own choice whereas only 19% of anorexics agreed. The groups also differed in the sense of 'success' and satisfaction they experience with their symptoms and their weight. Bulimics characteristically regard themselves as failures, whose symptoms of bingeing and purging are not consonant with their goals (Fairburn & Wilson, 1997), and whose daily life experience is often chaotic and disappointing, with repeated resolutions and attempts to change followed by the experience of loss of control. Anorexics seldom make equivalent efforts to change spontaneously.

While it is an oversimplification to characterise anorexic clients as purely opposed to change, it would be false to describe bulimics as entirely eager for it. They may not want any part of treatment while in the 'honeymoon' phase of their illness, when vomiting still seems like a satisfactory solution to the problem of weight control. Even after becoming disillusioned about the means, bulimics usually continue to desire the goal, and hope that therapy can eliminate their binge eating so that they can be better dieters. Bingeing and purging themselves possess a variety of positively and negatively reinforcing properties that bulimics are reluctant to lose. Most obviously, the symptoms allow individuals to eat favourite foods without incurring their full caloric cost. They can also interrupt negative emotions and provide escape from self-awareness and painful memories.

In spite of these perceived advantages, it is clear that anorexia nervosa and bulimia nervosa differ markedly in the extent to which symptom resolution is desired, sought, achieved, and maintained. The positive valuation of symptoms seems a principal reason why anorexics fare less well in treatment. Much of this discussion about enhancing motivation for change refers to anorexia nervosa, where resistance is such a central feature. The same principles, however, can extend to work with any eating-disordered clients in whom ambivalence is marked. This includes bulimics in the earlier phases of their disorder, bulimics who are desperate to stop bingeing but reluctant to stop dieting, and subclinical cases who are preoccupied with similar issues without ever attaining low weight status. In fact, these principles represent good therapeutic practice for all individuals with eating and weight concerns – it just becomes especially crucial to implement them systematically in proportion to patients' investment in the status quo.

Empathy and validation

The following suggestions for enhancing motivation for change are drawn from a paper written in conjunction with Susan Watson and Terry Wilson (Vitousek, Watson, & Wilson, In press). We cannot expect our patients to listen to us if we do not understand their experience, if we do not understand why we are being resisted. The most important shift we must make to increase the possibility that we will be helpful has nothing to do with specific techniques – it has to do with the development of genuine empathy for the anorexic experience.

A great deal has been written about the importance of conveying empathy to eating disordered individuals, but little about how we might try to develop it in the first place. For many clinicians, it does not come automatically or easily. As Sheila MacLeod (1982) wrote: *individual therapy has been devalued because* [among other reasons], *psychotherapists do not like anorexics, and anorexics do not like psychotherapists.* We need to acquire a frame of reference that helps us 'get' this condition before we can use specific techniques effectively. The following four related principles have been found to be helpful to underscore when sensitising novice therapists to this population.

Appreciate the fully egosyntonic nature of thinness and self-control

It is hard for clinicians to come to terms with the fact that most anorexics want to be doing what they are doing. Therapists who do not grasp this point miss how incongruous it is to warn an anorexic whose weight is declining that she is in danger of relapse for that is probably her intent. There is no point spending a session instructing an experienced anorexic that if she doesn't add in more calories and more fats at breakfast and lunch, she is going to lose weight. She knows that and we need to recognise where she is, and work forcefully at that point, not somewhere downstream. The failure to accept that these clients really do want to be thin is the most fundamental error that clinicians commonly make in their work with this population.

Recognise the desperation that drives symptom 'choice'

It may seem inconsistent to state that the symptoms our clients are embracing are also compelled, but in fact there is no conflict between those observations. Most of us view the eating disorders as attempts to cope with a profound sense of inadequacy. We must not forget that the 'willful' behaviour of an anorexic is the response of someone who is absolutely miserable. To overlook either the desire or fear is to misunderstand the complexity of the predicament.

Do not attach surplus meaning to resistance

We need to remember that *In reality...these patients have not asked for our help* (Wulliemier, 1978, p. 498). We are proposing to fix one of the few parts of their lives that they do not consider broken. The parent who is told that it is to his benefit to have his child taken away would, perhaps, be willing to deceive, fight, or flee if necessary to protect the child, and would feel no compunction about 'resistance.' It can be professionally irresponsible to be offended when anorexic clients act anorexic, just as it would be to interpret an obsessive-compulsive client's handwashing as a personal affront. It is our job to convince prospective clients that change is possible and desirable, not the client's responsibility to eliminate doubt as a precondition for treatment eligibility.

Acknowledge the difficulty of change

We should treat very respectfully what we expect the anorexic client to do on the strength of our authority as experts. Sympathetic acknowledgment of the desperation felt and sincere regard for any courage that can be mustered are appropriate, and they are appreciated.

Socratic style

There needs to be consideration given to the set that seems most helpful for clinicians to bring to therapy, or the way of 'seeing' their clients' difficulties that appears to promote empathy. Personal experience of therapist training suggests that through analogies, reading patient accounts, role-playing exercises, and listening, most trainees do manage to acquire a more sensitive and less judgmental perspective on this disorder.

The style that seems most effective in work with anorexic clients is much harder to acquire. The style that we recommend is a time-honored one, the Socratic approach, which uses a series of questions to help clients reach conclusions themselves. The style obviously has an ancient pedigree as a teaching technique and, in recent years, it is increasingly recognised as a powerful therapeutic method, particularly well suited for work with resistant clients. Miller and Rollnick's (1991) influential book on motivational interviewing is essentially an adaptation of the approach designed to engage alcoholic clients in treatment. Hilde Bruch was recommending it years ago as specifically appropriate for the anorexic population. She said that it was decisive that the patient experience herself as an active participant in the therapeutic process. She advised us to avoid making interpretations, instead giving the patient the chance to make discoveries on her own and 'say it first' (Bruch, 1973).

The approach is essentially, fundamentally, irreducibly collaborative. It assumes that you can only work within the patient's system to produce change and that, by definition, you will fail if you attempt to impose change from outside. That does not mean you must accept the status quo because the patient does, it means that you work actively, forcefully, and (you hope) persuasively to encourage them to question the status quo in their own terms. You respect individuality in your whole style of relating to the patient. You must, because it is her world you must enter, her language you must speak, in order to introduce the possibility of change. We should be scrupulous in avoiding statements that stereotype or patronise her. Comments such as *Like all anorexics, I'll bet you ...* or *As you will find out .....* or *Everyone with an eating disorder feels that way*. Each of these statements, in addition to being offensive, is incompatible with the genuine sense of collaborative discovery that should be the basis for treatment. Instead, we should be liberal in our use of phrases that reinforce individuality: *Everyone is different..., I don't know what it's like for you ..., Some of my clients say ... but others disagree ... What has your experience been like?*

In this model, the client's thoughts and feelings are viewed as hypotheses that both of us work together to sort out. Feedback on the therapist's approach is encouraged, and emphasis is placed on client choice rather than therapist control. We do not, however, endorse the view that the clinician's agenda should be subordinated to the client's, that our job is simply to be supportive and reflective until she is 'ready' for change. The therapist's role is to get her ready for change, and then help her to set about actually changing. Clients are authorities on their own 'lived experience' but they are not knowledgeable about the effects of starvation on cognitive functioning, emotional equilibrium, and vulnerability to binge eating. It is irresponsible to restrict the direction of therapy to the options recognised by clients, since these choices are constrained by the psychopathology and physiology of their disorders. The question is not whether to modify the status quo, but how best to accomplish this objective (Miller & Rollnick, 1991) and the Socratic style is an active, purposeful means of doing so.

Psychoeducational theme

The first of four themes we find most helpful in enhancing motivation for change (Vitousek, Watson & Wilson, in press) is the introduction of psychoeducational material. Most of us who specialise in the treatment of eating disorders have developed a good deal of respect for the contribution of this element. Psychoeducation is a prominent part of cognitive therapy (Garner & Bemis, 1982); feminist therapists have described it as antithetical to paternalistic care, since the whole approach assumes that clients are empowered when they have the facts and can make their own decisions (Olmsted & Kaplan, 1995). However, many clinicians underutilise this critical aspect of treatment and do not always recognise what a major part it can play in building motivation for change.

A detailed review of the Minnesota experimental study of semi-starvation may be as influential as any form of interpersonal support or coercion in engaging new anorexic clients in treatment. Ironically, the most powerful research ever done in terms of its implications for understanding anorexia nervosa was an arguably unethical piece of work undertaken more than 50 years ago, conducted with normal male subjects by male researchers. Those who have worked with this population are probably at least generally familiar with this study and may have read the whole of the massive two-volume work on human starvation from cover-to-cover (Keys, Brozek, Henschel, Mickelson, & Taylor, 1950). Many portions are required reading for my own graduate students before they first encounter an anorexic patient in therapy. An abbreviated insight can be located in Garner's chapter on psychoeducational material in the recent revision of the *Handbook of treatment for eating disorders* (1997), which includes lengthy excerpts from Keys et al.

The purpose of this study was to find out what was happening to people who were undergoing semi-starvation in prisoner of war or concentration camps, or in the widespread general famine that affected many areas of Europe and Asia during World War II. The subjects were carefully selected, impeccably healthy male volunteers who were conscientious objectors to military service. They were first observed and tested over three months while remaining on a normal dietary regimen. They were then subjected to six months of semi-starvation, eating an average of about 1500 calories a day, and losing an average of 25% of their original body weight. Subsequently, they were followed through an extended period of nutritional rehabilitation and its aftermath.

Not surprisingly, the subjects developed most of the physical symptoms associated with anorexia nervosa: low body temperature, low heart rate and blood pressure, and a wide range of physiological abnormalities. They also acquired precisely the same distinctive, eccentric food-related behaviours that anorexic individuals display. They became obsessively preoccupied with food; they started collecting recipes and discussing menus. They acquired unusual habits such as ritualistic eating behaviours and mixing together unappetising combinations of foods; they developed preferences for spicy, salty, and hot foods; they spent inordinate amounts of time eating their meagre portions, and they began chewing gum excessively. Of particular relevance to our interpretation of bulimia was that some periodically broke down and had binge-eating episodes in violation of the experimental protocol and their own intention to comply with it as the 'conscientious' individuals they were.

Most surprising to the researchers, and most important for our purposes, was that the participants also manifested striking emotional and social changes. The investigators were shocked by the extent of psychological deterioration that occurred in these previously healthy, well-adjusted men. In fact, they coined the term 'semi-starvation neurosis' to describe what they saw taking place. Every participant in the study became depressed, with reactions ranging from mild dysphoria to severe affective disturbance; many became irritable; some developed anxious or obsessive-compulsive symptomatology; a few displayed 'psychotic-like' phenomena. Most became socially withdrawn. They were no longer interested in friends or normal social exchanges, but preferred to be isolated, or to converse about food. Notably, most reported a pronounced decrease in their sexual interest. A telling anecdote from the study is that some of the men took down the pin-ups of women they had posted in their rooms, and replaced them with photographs of food. This is a rather compelling illustration of the principle that there is a hierarchy in the drives influencing our interests and desires.

This single study encapsulates some of the most critical messages we have to offer to anorexic individuals that include:

(a) Starvation is the unifying cause of an array of distressing experiences that clients may perceive as unrelated. Because they are starving they are cold; their hair is falling out; they are preoccupied with food; they like cookbooks and spicy food; they are moody and withdrawn, and they are inefficient and perseverative.

(b) The consistency of the starvation syndrome has both reassuring and disturbing implications for anorexics. The symptoms that they do not like are not mysterious, independent, personal, or permanent. The voracious appetite that terrifies them does not signify 'moral weakness' (as clients often think) or 'emotional hunger' (as many therapists would put it). It is an inevitable consequence of restriction, and it will eventually abate only after the deprivation stops. They should not be told to 'get in touch with their hunger.' Hunger has them in its grasp and whether you want to call it 'genuine' depends on whether you mean 'genuine', as meaning real and natural and built into the organism as a response to prolonged deprivation, which it is. Or whether you mean 'genuine' as being trustworthy and sensitive and responsive to fine grained shifts in intake and output, which it is not, either at present, and not for some time to come. It is even more cruel and futile to ask them to get in touch with their 'authentic hunger and fullness' than it would have been to encourage the Minnesota subjects to do the same.

At the same time, the egosyntonic experience of being special and unique through the disorder is belied by its utter predictability. Many of the secret things that anorexic individuals feel and do were felt and done by male volunteers who were not given enough food to eat 50 years ago. Anorexic patients often react to anecdotal material from the Minnesota study with confusion and chagrin and it may evoke the first sense of dissonance required to develop a disposition to change.

The form in which psychoeducational material is presented strongly affects its impact. One important principle is that we need to say enough to make scientific research meaningful. We should not merely summarise conclusions, but explicate the process of inquiry in enough detail so that the data become directly accessible and interpretable to clients. For example it is no more likely that a bulimic will swear off cathartics once instructed that 'laxatives don't work' than a patient experiencing panic will recover as soon as an emergency room physician dismisses his cardiac concerns as unfounded. Sufficient information should be shared to make it possible for the client to understand how and why we know what we know. With reference to the ineffectiveness of laxatives, we should describe the methodology of measuring the absorption and excretion of calories with and without laxatives (Bo-Linn, Santa Ana, Morawski, & Fordtran, 1983), and show clients a graph that illustrates the results of such research thereby revealing the trivial caloric differential obtained. The data should be translated into concrete terms, for example *So, this study says that if you consume a bag of popcorn, a pint of ice cream, six chocolate cookies, and a banana, you will cancel out half the banana and a cookie by taking a handful of Ex-Lax.'* We should connect experimental results back to the individual case: *Does that fit with your own experience of seeing the numbers on the scale drop the morning after you take laxatives, but go right back up again as soon as you get rehydrated?* It is a concept similar to good teaching where we are not just telling students in our classrooms the facts, but explaining how they were obtained.

Psychoeducational work is one instance where the 'expert stance' is fully appropriate. In this area, it is our responsibility to impart facts patients cannot learn from their own phenomenological experience, because they do not know, or only partially know, the correct attribution for what they feel. But it still matters a great deal how it is done, and it is critical to follow the Socratic style when presenting this material, rather than lecturing clients about the consequences of their behaviour.

Experimental theme

The second core theme of therapy relevant to enhancing motivation for change is an experimental emphasis. The collaborative empirical model seems to especially suit the needs of these wary, ambivalent clients who are quite understandably reluctant to take the word of an expert about the need to make changes in behaviours that they find both reassuring and reinforcing. It makes sense that they are much more responsive to evidence they have collected and verified themselves. We need to emphasise from our very first meeting with the client that each step in therapy will be undertaken with an attitude of 'let's test this out and see what happens' (Garner & Bemis, 1982). That emphasis is not just strategic but also reflects reality. For bulimics and all but the most imperilled anorexics, the entire therapeutic enterprise is an experiment from which clients can choose to withdraw. There is no point bluffing about this for everything is in the patient's hands. The option of returning to the disorder remains available to those who still prefer it after examining its implications and exploring other alternatives, and it is both persuasive and honest to acknowledge that fact openly. The same principles hold for all of the changes we ask our clients to consider - adding new foods, gaining weight, trying new activities.

Functional theme

The third theme in therapy is an emphasis on the functional effects of symptoms. When you are dealing with beliefs that are highly valued by individuals or are culturally shared by everyone around them, there are limits to how far you will get by challenging the accuracy or rationality of such beliefs. Instead, we avoid arguments about what is 'true' or 'false' by asking clients to explore the consequences of their beliefs and behaviours. The most explicit application of the functional emphasis is a review of advantages and disadvantages (Vitousek & Orimoto, 1993). I often come to the end of my first several sessions with a new anorexic client knowing little about her family dynamics or childhood experience. This may not be because such things are unimportant, but because it will be possible to explore them later - if she has decided to come back. We have spent that critical, early phase of therapy developing and discussing an extensive list of the advantages and disadvantages she sees in being anorexic - as well as the pros and cons of change, also in her own terms. Some potential results include:

Perceived advantages of anorexic behaviour

What everyone else tries to do, I show that I can do better.
I can keep people at a distance.
I don't have any menstrual periods.
I feel healthier and more energetic.
I feel powerful when I don't eat.
I like the feeling of self-control.
I feel like I am in touch with the sufferings of the world.

Perceived advantages of bulimic behaviour

I can eat anything I want without getting fat.
I can numb out everything that's bothering me.
It helps me cope with anger and anxiety.
I like the feeling of 'getting away' with something.
It is one time I can focus only on myself.
It relieves boredom.
Vomiting makes me feel cleansed.

Such lists may not be entirely honest because as yet, the client may have little basis for trusting the therapist. They are certainly not complete even if the client is being candid, in the sense that they do not capture all the functional relationships that may actually influence her behaviour.

The exercise does, however, serve a number of very important purposes. It is disarming to patients that the therapist is keenly and genuinely interested in what they think they are getting from their disorder. It also distinguishes the therapist from the family members and doctors who have been confronting them with what is wrong with what they are doing. Confronting a patient with the danger or foolishness of the behaviour only forces a defense of what has not been possible to modify. It pushes her into a corner from which she must argue against change while you argue for it - and that is an argument you will lose.

It is important to focus on the advantages first. When this is done, patients tend to be much more forthcoming about disclosing the disadvantages of their anorexic life. These are examples of the kinds of unwelcome concomitants they may acknowledge:

Perceived disadvantages of anorexic behaviour

Being thin takes up so much time and energy.
I can't eat a lot of the things I like.
People hassle me a lot about it.
I have trouble concentrating.
I don't like being cold all the time.
It's immoral to worry so much about how I look.
I hate being a cliché.

Perceived disadvantages of bulimic behaviour

It is a disgusting habit.
It costs a lot of money.
It promotes a constant focus on food.
I don't really enjoy what I eat anyway.
My relationships are suffering.
I have no pride or self-respect.
I will always feel intimidated by my family as long as I do this.

The process helps to map out some common ground by identifying the subset of issues that can be agreed upon and that would be desirable to change. It also allows the therapist to pose questions, very early, very gently, and very respectfully with reference to the client's own opinions about whether this is really going well, in their own terms. Is the disorder a pretty good 'package deal' for the client all things considered? The calculations that determine a client's balance are not always logical, and they are certainly not additive. It is not possible to just total up seven reasons for and five against, and reach a decision. Just as in the parenting analogy discussed earlier, a single dominant positive motivation can counterbalance numerous drawbacks. Therapists should raise the issue with patients about what they experience as central, and what as secondary or peripheral.

What should the therapist do if a client insists that the status quo truly is in her best interest? – this is not uncommon for anorexics or early-phase bulimics. There are several lines of inquiry helpful in probing her confidence in this conviction. If the eating disorder is working out pretty well, would they be pleased if their own daughter someday, decided to live the same way? I believe that only one client with whom I have worked has ever answered 'yes' to that question. For the rest, a negative answer allows the therapist to reframe their present position and suggest *So it's not that you think that this is the right or best way to live, but rather that it beats the other alternatives that seem to be available to you right now.*

It is also helpful to project the status quo into the future (Garner & Bemis, 1982). If the trade-offs seem acceptable at present, does the client think they will remain, say five or ten years from now? Many clients have not given much thought to the long-term outlook of chronic anorexia or bulimia and most of those who do shrink from the prospect.

Perhaps the most revealing question is to ask the client what they think they will do to manage the negative effects that are acknowledged. Willingness to stick with the status quo is often based on the false premise that the disorder is really not a package deal, the sense that some day, somehow, once they really get it right, they will be able to retain the benefits they associate with their symptoms and keep their thinness, while eliminating its liabilities. David Garner calls this the 'anorexic wish' or the desire for two mutually exclusive events (Garner, Vitousek, & Pike, 1997). The fantasy takes many forms, but the theme is the same: *I will feel better if I focus on my emotional problems instead of my weight...I can recover through the compromise of gaining just a little weight...* However, in reality the pros and cons of an eating disorder are inextricably linked – no one can eliminate just the unwanted bits selectively. There is no way to 'get it right' – in fact, the ratio of positive and negative effects tends to grow less favourable over time.

The patients' own pro and con lists confirm this for they are full of internal inconsistencies such as: *An advantage is that people pay attention to me – a disadvantage is that I wish they would leave me alone; An advantage is that people admire me – but I have lost interest in all of my friends; I feel powerful and proud – I'm always depressed; I like my control over my appetite – I am totally obsessed with food.* These are inherent contradictions and conflicts between the client's perceptions rather than between their views and those of the therapist.

It is possible to juxtapose these discrepancies without commenting on them or confronting the client with them in any negative sense. This can done by suggesting: *In your experience, then, thinness is desirable in part because people pay attention to it – but you also wish that they would stop bothering you, and no longer care if they admire or disapprove of the way you look.* There is a need to be very careful to avoid sounding smug or challenging for there should be no sense that you have trapped the client into a contradiction. The sense should be that you are trying to understand her own predicament from the inside.

Then, the therapist can begin encouraging her to consider an alternative, to explore whether different coping mechanisms might yield the same or better benefits at lower price. Most of the client's goals, qualities like self-control, emotional stability, respect from others, are separable from the means she has relied on. It is the means that cannot be detached from their consequences. We can affirm the appropriateness of the client's objectives while encouraging her to broaden and refine her repertoire of techniques.

The adaptive functions the client identifies must be replaced, not just removed, for people do not cheerfully or voluntarily give up useful behaviours without the prospect of getting something at least as good in return. We recommend telling clients explicitly that therapy is the search for a better deal. This does not happen overnight, and in fact, they may have to endure a dry spell when the reinforcers associated with their eating disorder have disappeared, but the new gratifications that will eventually follow recovery are not yet in place. That is one of the factors they have to consider as they contemplate the prospect of change, and the courage required to give up a severe eating disorder should be acknowledged, respected, and supported, rather than minimized.

Philosophical theme

The last set of recommendations for enhancing motivation is listed under the heading 'philosophical' and it probably includes the most controversial of our recommendations. Some of us feel uncomfortable when eating disordered clients drag notions about morality, aesthetics, and the purpose of life into psychotherapy. If therapists have a behavioural background, they may see such material as digressions from the food and weight problems at hand or, if you are experientially inclined, as flights into intellect. In fact, abstract principles are the native language of many anorexic clients. If such discussions are barred from treatment, therapists may misunderstand clients, to whom such matters are never irrelevant, and may forfeit the best chance to transform the meaning of their egosyntonic symptoms.

Anorexia nervosa can be seen as unusually 'top down' in its derivation, in that it can be deduced (though without impeccable logic) from a set of principles about how one should be and behave. As Mogul (1980) wrote, anorexics *generally have a sense of being concerned with the 'higher things' in life* [and] *a disdain for the worldliness around them* (p. 162). Their ethical standards are exacting, intolerant of error, weakness, or waste in others and especially themselves. Even their private thoughts may be shaped into a characteristic 'New Year's resolution' form (Vitousek &

Hollon, 1990): 'I must succeed in giving up my bad behaviours and truly commit myself to being good – and I shall be a better person for my efforts'. Because these values support the symptoms of food restriction and weight loss, resistance to change can be principled as well as functional or automatic. As one of my anorexic clients wrote:

> I can't get free of the idea that a person who is slim and in shape has higher values, is more disciplined, has more guts, is less materialistic. I despise people who are status and consumption oriented ... If I were to eat much more and thus gain much more, I couldn't help but see myself as increasingly ugly and impulsive, a person who can't delay gratification or endure hardship, a person who takes more than gives – maybe even a person who doesn't know right from wrong.

Marilyn Lawrence (1979) was correct when she wrote that anorexia is better understood as a moral quest than as a silly cosmetic obsession, but its spiritual pretensions don't bear close scrutiny. Anorexics derive quite worldly gratification from their self-restraint and they expect to be admired as well as purified through their thinness. The same client who expressed contempt for people who are 'status-oriented' and 'take more than give' continued as follows:

> (My weight provides) *a valued edge over others. I've never wanted to settle for average – I always wanted to be better or special in some way ... I guess I just want to feel superior – yet I hate myself for my elitist attitudes.*

Certainly, we do not mean to try to foster self-loathing in therapy, rather the intention is to develop dissonance between symptoms and self as implied in this second passage. To that end, it is necessary to work with the 'self' as found, at least initially. It is not helpful to point out how the client's pathology conflicts with the more flexible, accepting, and pleasure-oriented standards that we may endorse. The question is whether it conforms to the rules honoured by the client, which tend to be quite different. Dissonance with someone else's views is irrelevant for the aim is to get them disagreeing with themselves. At this level the internal consistency of beliefs and behaviours is being examined not their validity, their utility, or their wisdom.

An asset here is that anorexics are particularly unlikely to resolve dissonance by discarding inconvenient principles. It is not in the anorexic repertoire to acknowledge that something is 'inconsistent,' 'immoral,' 'dishonorable,' or 'weak' and yet cheerfully do it anyway (which many other patients will do). They actually recognise no greater failing than an inability to conform their conduct to their convictions. If the clients' beliefs about the 'rightness' of anorexia can be changed, the principled stubbornness that helped create the disorder can be an asset in resolving it. By working on several levels: Clients can be encouraged to examine inconsistencies between their symptoms and their values, to look at inconsistencies between different principles that they esteem, and to examine the functional effects of conforming to the tenets that they hold. Sometimes clients are already aware of discrepancies between their symptoms and their values. Sometimes they are unaware, and it becomes the therapist's role to bring them to their attention, albeit very gently.

One of the most common examples is a perversion of the meanings of 'strength' and 'control'. Clients often interpret self-deprivation and ritualistic behaviours as triumphs of will power over weakness. In fact, for these individuals, they are nothing of the sort: They represent the easy way out of difficult situations. For an anorexic, the decision to skip a meal or run an extra mile is the functional and moral equivalent of an agoraphobic deciding to stay home, or an alcoholic deciding to have another drink. Because anorexic clients tend to prize challenge over comfort, the egosyntonic value of symptoms depends on their assumption that the disorder is a brave and difficult thing to do. Without belittling either, we can reframe the relationship between the behaviours and the underlying principles. As an example, one of my clients was a devout Catholic who had welcomed each Lenten season since the onset of her eating disorder. For 40 days and nights, her determination to diet was supported by her sacred pledge to give up the foods that tempted her, as a Lenten promise. Lent also provided a useful cover story for her frugal consumption – nobody bothered her much about her restrictive eating, because she could refer to her religious practice. During therapy, the client's understanding of her real motives shifted. She realised that for her, restrictive eating was in fact self-indulgent rather than self-denying. In terms of her own religious principles, it actually mocked the spiritual purpose she had claimed for it. Quite on her own she decided to make a new vow whereby, for the duration of Lent, she would eat three ample meals 'religiously' every day, incorporating foods she denied herself throughout the year.

Therapists who are attentive to the client's own value system can help them recognise many other ways in which their disorder violates the principles they esteem. In fact, for the anorexic individual, the disorder is not difficult but cheap (in that it is the easiest decision she can make at any given moment). It is not distinctive, but stereotyping, in that anorexia makes her much more predictable than she was before the disorder, and much more than she will be if she can manage to recover from it. It does not clarify, but confuses; it does not serve higher goals, but blocks her in her attempts to attain them.

The decision to work through the values that clients bring to therapy is not paradoxical, and should not be seen as a capitulation to psychopathology. It should be considered as both pragmatic and respectful of individual differences. Sometimes a sort of tyranny can be discerned in the therapeutic insistence on a set of values held as a profession. For example, we tend to favour affective expression and the acceptance of nurturance. Those preferences come from our code, not theirs, and in my opinion it is grandiose (and disrespectful as well) to think that we can or should change the whole substrate.

Moreover, the moral code to which these clients subscribe is not really the problem, even if you favour a different one personally. The problem is its garbled translation. Millions of others have endorsed similar beliefs without manifesting the same symptoms. Later in therapy, it is desirable to explore whether more moderate and mature interpretations advance the client's interests better than absolutistic ones. However, even then, appeals consonant with the client's existing beliefs are likely to be more influential than arguments originating in a radically different world-view.

Conclusion

The end of the initial stage of intervention is reached when the client makes a tentative decision to experiment with the possibility of living differently. In some cases, that happens before intake or after just one or two sessions that concentrate on tipping the balance of ambivalence. In others, weeks or months of persuasive efforts may be required before clients are willing to attempt significant behavioural change. However, it is important that therapy not stall at the level of discussing the client's motivation for change. The client's preliminary decisions to explore different ways of doing things should immediately and repeatedly be put into practice. Ambivalence is better resolved through direct experience than through abstraction. At some point, there is no substitute for the client simply proceeding to do the things that are found frightening, in spite of persistent uncertainty.

The style and strategies that are recommended for the focal objective of enhancing motivation for change clearly must be implemented within a broader context that describes how to manage all of the complex problems that eating-disordered clients present. For more detailed descriptions of the model most consonant with this approach, one can refer to articles and manuals on cognitive-behavioural therapy for anorexia nervosa and bulimia nervosa (e.g., Fairburn, 1995; Fairburn, Marcus, & Wilson, 1993; Fairburn & Wilson, 1997; Garner & Bemis, 1982, 1985; Garner, Vitousek & Pike, 1997; Wilson, Fairburn, & Agras, 1997). It can be both striking and reassuring that similar recommendations for developing motivation for treatment recur across conceptually distinct therapeutic approaches. The problems presented by underweight individuals who are determined to preserve their symptoms seem to override theoretical allegiances, and dictate important commonalties in treatment approach.

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Chapter 12 – Eating Disorders and Disturbed Body Image: A View from Psychology

Lois Surgenor and Chris Thornton

Historically, anorexia nervosa (AN) and bulimia nervosa (BN) have been variously described as anxiety disorders (Goldbloom & Garfinkel, 1993), as variants of mood disorder (Cantwell, Sturzenberger, Burroughs, Salkin, & Green, 1977) and, in earlier writings, as forms of schizophrenia, hysteria, and malingering (see Garfinkel, Kennedy, & Kaplan, 1995, for an overview of these historical accounts). Despite these respective nosological shifts, psychological issues remain centrally represented in both etiological and treatment models of eating disorders. Although different theories emphasise different pathways and developmental dilemmas, common psychological disturbances include impaired identity development, impaired sense of self, impaired self-esteem, and impaired processing of subjective experience, including impaired emotional life and affect regulation (de Groot & Rodin, 1998). While stringent empirical evidence is available only for a narrow range of psychological treatments, a wider range of mainstream approaches are supported by professional practice guidelines and texts (American Psychiatric Association, 1993; Mizes, 1998). Good clinical practice dictates that treatment providers work within their arena of competence and training, seek supervision, and know clearly when to initiate wider consultation.

Treatment is rarely simple, and often complex. Although treatment manuals are readily available for some types of eating disorders (especially BN), and help access mainstream processes and tasks, potential pitfalls of such manuals include absence of attention to individualised case formulation, rigidity in the application of techniques, and under-emphasis of the importance of the client-therapist relationship (Arnow, 1999). Treatment of the more severe cases is a specialist activity, and even experts seek consultation and collaboration. Invariably a range of health disciplines may need to be involved in treatment, especially with respect to AN, as eating disorders pose a widespread burden on the individual. Any theory advocating a unidimensional explanation or any individual promising a cure must be treated with considerable caution.

This chapter outlines some common treatment approaches and issues from the perspective of psychology. By nature of the context of this publication, special emphasis is given to the issues of body image. Following an introduction to issues for health and education professionals managing people with eating disorders, the chapter summarises a range of psychological treatment approaches. The latter part of the chapter more explicitly discusses approaches to body image disturbance.

All approaches hope to get the client well, and although they may place different emphasis on different symptoms, at some general level recovery needs to include the normalisation of psychological functioning, weight and nutritional normality, and the cessation of symptoms such as bingeing, purging, and restricting. Of note, clients' views on their recovery rarely feature in the outcome literature (Jarman & Walsh, 1999), and this an area awaiting further investigation.

Psychological issues for health workers managing people with eating disorders

When encountering people with any significant psychological or psychiatric condition, it is not uncommon for health professionals to note that such conditions may provoke emotional reactions and feelings in themselves. Reactions and feelings expressed by those who encounter people with eating disorders can be especially varied. While most who choose to work in the field do so because of a genuine interest and compassion, the therapeutic encounter can be both rewarding, surprisingly taxing, and provoke a special set of reactions. Although the term has a number of meanings, 'negative transference' commonly refers to any negative emotional, behavioural, or attitudinal reactions in health professionals that are inappropriate or risk interference in the therapeutic relationship.

For several reasons, the field of eating disorders poses special issues in this respect. While there has been a dramatic surge of clinical, research, public, and media interest over the past 20 years, knowledge and attitudes about eating disorders amongst many health professionals remains a source of concern (Vandereycken, 1993; Beumont & Vandereycken, 1998). Lay people also do not have a consistent or accurate view of eating disorders, with many people believing AN simply to be the reverse of obesity (Furnham & Manning, 1997). Knowledge biases or out of date knowledge may mean that clinicians actively avoid people with eating disorders, or worse, adopt punitive attitudes in their interactions with them (Fleming & Szmukler, 1992; Brotman, Stern, & Herzog, 1984). Although this may reflect inadequate training or currency in an admittedly rapidly advancing field, a further source of emotional reactions may involve the type of pathology or the natural course of eating disorders. In short, the high rates of morbidity and mortality (Herzog, Nussbaum, & Marmor, 1996; Sullivan, 1995) make eating disorders dangerous and complex phenomena.

Clinicians adhering to superficial understandings of the wider psychological predicaments of people with eating disorders are at risk of adopting an anti-therapeutic stance. An example of such views may include the belief that an eating disorder *is born out of vanity or envy* [and that] *their eating pattern has deteriorated because of stubbornness (anorexia) or lack of willpower (bulimia)* (Beumont & Vandereycken, 1998, p. 3). Although many symptoms can be experienced as shameful or distressing, other symptoms can be highly reinforcing and valued (Serpell, Treasure, Teasdale, & Sullivan, 1999). This can seem inexplicable to a naïve enquirer.

Furthermore, power and control issues are argued by many to be at the heart of many eating disorders, especially AN (Jarman, Smith, & Walsh, 1997; Fairburn, Shafran, & Cooper, 1999). Faced with the saliency of such issues, the health professional must resist any urge to 'compete back' or enter into any power struggle. Left unchecked, once this process is underway, the risk is that treatment or the therapeutic relationship itself becomes subverted into a power struggle.

These issues permeate all models of treatment and if unchecked, risk under involvement or over-involvement by health professionals. While over-involvement may take the form of explicit boundary violations or unnecessarily over-vigorous application of treatment technologies, examples of under-treatment may be more subtle and harder to detect. Examples include 'giving up' the belief that recovery is possible, or reducing the frequency of appointments 'until she proves to me that she wants to get well'. Psychological issues for those working with people with eating disorders are real. For this reason, clinical supervision is advised as is close contact with registered health professionals and if possible, reputable specialist centres.

Psychoeducation

At the most general level, an important component in assisting people with eating disorder is to provide education and information. Historically this has occurred through a variety of means, although irrespective of means, its focus is usually both educational and therapeutic. Most simply, psychoeducation refers to *the provision of information to the patient about the patient's disorder and methods for overcoming it for the purposes of promoting attitudinal and behavioural change* (Olmsted & Kaplan, 1995, p. 299). Psychoeducation is an important component of change and recovery, and is embedded within the process of many schools of psychotherapy. Not only does illness information improve the likelihood of independent change on the part of the client, but it is also argued to increase client adherence to difficult treatment decisions (Pomerleau and Rodin, 1996). As specialist treatment resources are likely to remain limited, this type of treatment is perhaps more accessible and can be utilized by non-specialist therapists.

Brief psychoeducation-focussed treatment alone can help many people with eating disorders (Olmsted et al. 1991), although more usually psychoeduation compliments or is explicitly combined with other psychotherapeutic modalities. In selected cases, this alone may be all that is required, or can be undertaken while awaiting access to other specialists. It should be noted that family and significant others of the client report equal interest in learning such information and education (Surgenor, Rau, & Fear, in press). The means of delivering psychoeducation can be by groups or on an individual basis, through the provision of written material (eg Fairburn, 1995; Schmidt & Treasure, 1993) or even via computer-based programs (Andrewes et al. 1996) although the content should always be matched sensitively to the needs of the particular person. Furthermore, clinicians delivering such programs must have a good grasp of the curricula, yet be prepared to admit the limitation of current knowledge about eating disorders. Many clients are themselves very knowledgeable about eating disorders, and will quickly detect misinformation or inconsistencies. This does little for the establishment of trust.

As described by Garner (1997) and Garner et al. (1985) typical core curricula include information derived from the scientific literature and covering the following:

i) Education about the numerous individual, familial, and cultural factors thought to increase the risk of the development of eating disorders. These factors include the pressure to diet, how families function under adversity, how people manage developmental changes, and individual factors.

ii) Factors affecting body weight regulation, including metabolism, set point theory, and genetic determiners of weight.

iii) The physiological and psychological effects of starvation and prolonged dietary restraint. This includes specific effects on behaviour, emotional life, and cognition. For example, few people with eating disorders realise that normal consequences of prolonged restriction alone is to experience profound food preoccupations, become more withdrawn and isolated, and have increased risk of binge eating (Keys et al. 1950).

iv) The process of restoring normal eating patterns. This includes specific techniques such as meal planning and self-monitoring, along with goals of increasing food variety and nutritional quantity.

v) The effects of purging on weight control, food cravings, binge eating, and further dieting.

vi) Identification of healthy and normal body weight ranges and fluctuations.

vii) The physical and medical complications of eating disorders, including short-term and long-term effects.

viii) Preparation and rehearsal for the management of potential relapses and slips in progress. For example, this might include predicting cues or interrupting urges to restrict or binge.

Interpersonal psychotherapy

As is often the case in psychology and psychiatry, forms of treatment specifically developed in other arenas (such as problems of depression and substance abuse) have also been applied to eating disorders. One such treatment is brief interpersonal psychotherapy (IPT) developed by Klerman and Weissman (1993) and others and modified by Fairburn (1997) to the management of bulimia nervosa. Here, it is argued that, although people may experience various routes into the eating disorder, interpersonal difficulties contribute to the onset and maintenance of the condition.

IPT is time-limited (up to 20 sessions), non-interpretative, individual psychotherapy with a focus on linking current interpersonal problems and interpersonal functioning to eating problems, although the eating disorder symptoms per se are explicitly never directly the focus of sessions. IPT focuses primarily on the client's present rather than his/her past. Neither the content of sessions nor the treatment time frame is open-ended.

Treatment is conducted in three distinct stages. In the first stage of this treatment lasting between 3-5 sessions interpersonal difficulties are identified by means of a comprehensive review of past and present relationships. Following a review of this interpersonal 'life chart', typically one of four common problem areas is chosen as a focus (grief, interpersonal deficits, interpersonal disputes, or role transitions). The area of grief within this context is defined as problems associated with any loss of a significant relationship. The area of interpersonal deficits refers to difficulties in initiating or maintaining intimate relationships. This may occur due to inadequate social skills, or other reasons. In any event, the person may experience significant social isolation, impaired achievement of developmental tasks, and social withdrawal. Role transitions include problems coping with life changes, loss of previous roles, or changes in health or work roles. This includes situations altering one's self-view. Finally, interpersonal role disputes refers to situations in which the individual and at least one other important person (e.g., spouse, friend, parent, or employer) have non-reciprocal expectations about the relationship. Such problems may arise through, for example, disturbed patterns of communication or conflicting life values.

Initial studies suggest that role disputes and role transitions are by far the more common problem areas chosen as focus areas by people with eating disorders (Fairburn 1997). Although the content of remaining treatment is directed by the choice of problem area, the techniques and processes used in this treatment may be similar across the choices. Furthermore, while the link between the chosen area and the client's eating problem is not the direct focus, in this first treatment psychotherapy stage some connection is established between these factors in the presentation of the rationale for this treatment.

The second stage (eight weekly sessions suggested by Fairburn, 1997) encourages explicit change, with the client asked to generate alternative styles and strategies to be applied to the specified problem area. Strategies include identification of current examples of the interpersonal problem, perceived obstacles in managing the problem, generation of alternative solutions, and trialing selected solutions. In this stage of 'working through', discussion of eating disorder symptoms is once again discouraged. The final stage of treatment reviews the achievements and changes made, addresses termination of the therapeutic relationship, and rehearses the management of future difficulties in the selected arena of interpersonal functioning. Clients are encouraged to see that further improvement can be expected in the months after the finish of formal treatment, and that there is a risk of the future occurance of such difficulties. Booster sessions are not traditionally described in published accounts of IPT for eating disorders although the wider IPT literature describes options such as further sessions with the same therapist, involvement in a support group, or maintenance IPT (Frank, Kupfer, Cornes, & Morris, 1993).

Although the precise mechanism of action of IPT is unclear, the initiation of events or circumstances which somehow represent a 'fresh start' in the lives of such clients, and the resulting self-efficacy and self-esteem, is thought to be important (Brown, Adler, & Bifulco, 1988). While early research suggests promising effectiveness with respect to bulimia nervosa (Fairburn, et al. 1995) investigations with respect to anorexia nervosa are only underway (McKenzie et al. 1999). Accordingly, even its strongest advocate argues against IPT as a first line treatment and readers wanting to become better acquainted with IPT are strongly advised to consult specialist texts and manuals (eg Fairburn, 1997; Klerman & Weissman, 1993).

Feminist treatment perspectives

While there is no single feminist theory (Striegel-Moore, 1995), and no concrete consensus amongst feminists about the goals and methods of psychotherapy, feminist views argue for the centrality of social and gender-based power and control issues as relevant to both the development of eating disorders and treatment processes and goals required to rectify such states (Gilbert & Thompson, 1996). That is, the phenomena of eating disorders are located within gendered cultures, gendered political systems, and social contexts. Vulnerability to eating disorders emerges from contexts of power differentials, gender expectations, and prescribed female identity development.

Stated simply, *disturbances of appetite and the use of the body as a means of self-expression are symbolic of women's personal and cultural oppression* (Peters & Fallon, 1994, p. 352). Typical of such accounts, Orbach (1978) argues that a woman's decision to control eating is a purposeful attempt to control both the external situation of living in an inherently powerful world, and the internal situation of experiencing self as conflicted. The self is conflicted through, for example, the paradoxical injunctions of social forces demanding dependency, and the social learning of converting one's own wishes into caring and responding to others. Thwarted and unmet, Orbach (1985) argues that women's needs *go underground* (p. 84). Denying feelings of hunger and controlling eating represents two processes. An acquiescence to powerful social forces and perhaps also a political protest in that transcending hunger pangs represents an arena in which a woman can fight back, *make an impact in a world hostile to her sex* (p.167), and counteract invisibility.

In feminist writing about therapy, traditional power differentials between therapist and patient are to be minimised. Indeed, it is by means of a co-operative and egalitarian relationship with the therapist, that clients are seen as experts in their own condition, and encouraged to view themselves as legitimate agents of self, and to exercise this with a view to their own needs. While insight is important, empowerment is more important. Through such a relationship, psychological treatment encourages clients to examine the many contradictions in prescribed social roles, and encourages change rather than adaptation to these roles. That is, therapy works hard to avoid reinforcing the very gender-role stereotypes and power differentials implicated in the aetiology of eating disorders. Clients are encouraged to understand the functional nature of their symptoms, and seek change at two levels: at a social and political level (eg by challenging the cultural oppression of women) and at a personal level through regaining self-determination or 'personhood' (Zerbe, 1996) in the psychotherapy. Body image work also constitutes an important aspect of a feminist approach, and this may include exploring the historical roots of body issues, messages regarding sexuality, and developing alternative schemas (Hutchinson, 1994; Kearney-Cooke & Striegel-Moore, 1997). In short, recovery then involves changes in multiple relationships in the arena of self, body, and culture.

Consistent with the feminist intellectual traditions, evidence for the utility and effectiveness of treatment is found through descriptions of clients' authentic experiences and structural insights. Rather than scientific reports, such accounts are more typically found in the wider forums of essays, stories, informed reconstructions, and the development of critical theory (Vitousek, 1997).

Psychodynamic treatment perspectives

Psychological approaches emphasising psychodynamic perspectives often focus on identification, articulation, and organisation of subjective experience in relational and developmental contexts (de Groot & Rodin, 1998). While recent theoretical accounts include the work of Dare and Crowther (1995) and Goodsitt (1997), the earlier ideas of Hilde Bruch (1973, 1978, 1985) consistently inform this approach to treatment. For example, Bruch (1973) defines anorexia nervosa as a *desperate struggle for a self-respecting identity* (p. 250), as a *struggle for control, for a sense of identity, competence, and effectiveness* (p. 251). In short, eating disorders are related to developmental arrests or deficits. By the nature of its complex endowment with interpersonal, physiological, and psychological meaning, food readily lends itself as a means of solving or camouflaging such problems of living and ego-deficits. These problems become more pronounced at adolescence once the person is required to exert autonomy, act independently, and integrate new realms of functioning (eg sexuality).

The cause of such deficits is varied and can include abnormal patterns of family interaction, particularly with mother-daughter relationships, developmentally impaired self-regulation, and impaired learning of biological needs (Bruch, 1978). Denial of food is one defence against the feeling of not having a core sense of self, of feeling ineffective and powerless. Such self-denial is often experienced as virtuous and satisfying. Yet inevitably this personal attempt to exert some form of control overpowers the person and may be experienced as *uncontrollable impulses* (Bruch, 1973, p. 253) or abnormal preoccupations and rituals around food and eating.

Recovery from an eating disorder requires changes and corrections in a number of arenas, not just in the arena of overt symptoms such as deficient nutrition, although this is important and should occur in close interaction with other changes. Treatment is concerned with re-establishing 'normal' mechanisms of control and personal effectiveness, to develop the 'genuine self', and helping the client with an eating disorder experience self 'as self-directed and owning of her body' (Bruch, 1971). In keeping with psychodynamic treatment principles, the therapist is to focus not so much on content, but rather on the functional interaction between therapist and client as a means of achieving such goals. The therapist must adopt an active and empathic stance helping the client expand emotional awareness and validation of their own authentic experience. Indeed, it is the therapeutic encounter that provides for the client *a new intimate interpersonal relationship where what she has to say is listened to and made the object of exploration* (Bruch, 1985, p. 14). Successful provision of this encourages clients to rely on their own inner experience, and in doing so, overcome difficulties recognising and identifying internal bodily symptoms and differentiating them from emotions (interoceptive awareness).

Like many other treatments for eating disorders, the precise utility of psychodynamic approaches to eating disorders awaits further systematic evaluation through controlled studies. Nevertheless, expert clinicians cite favourable results in women with good motivation, high impulse control, and good psychological mindedness, while such approaches should be avoided in women with very severe eating disorders, suicidality, and significant comorbidity such as severe depression or substance abuse (de Groot & Rodin, 1998). As with any psychological approach, experience and training in the psychological modality is essential for safe and ethical practice.

The Cognitive behavioural treatment of eating disorders

As suggested above, even early modern formulations of anorexia nervosa (Bruch, 1973, 1978), although not cognitive behavioural in nature, emphasized the role of distorted attitudes to food, weight and shape as a prominent feature of the illness. Reduced to its essence the cognitive behavioural view of the eating disorders hypothesizes that eating disorders are maintained by an overvalued idea that self worth is contingent on appearance. Weight and shape are seen as the primary, or exclusive, construct in the determination of self-esteem.

Individuals who are at risk for developing this belief system are typically premorbidly perfectionistic, have low self esteem (Fairburn, Cooper, Doll & Welch, 1999; Slade, 1982) and have deficits in coping strategies (Kleinfield, Wagner & Halmi, 1996). If an external stressor disrupts the patient's need for control, she begins to look for ways to feel more in control of her world and to protect an already fragile self-esteem. In the context of Western culture's emphasis on thinness as a metaphor for female acceptability, the patient begins to focus on weight loss as a means of feeling in control. Dieting and weight loss are positively reinforced by social approval (at least initially), and then maintained by internal reinforcers such as the perception of increased control and self esteem. Negative reinforcers, such as the avoidance of being fat, avoidance of psychosexual maturation, and distraction from stressors other than weight and shape, also act to maintain the drive for thinness. Eventually, weight loss (as opposed to achieving a goal weight) becomes the sole measure of control and self worth. For more detail of the cognitive model of anorexia the reader is referred to Fairburn, Shafran & Cooper (1999); Garner, Vitousek & Pike (1997); Kleinfield, Wagner & Halmi (1996); Slade (1982) and Vitousek (1996).

For people who develop bulimia nervosa, the physiological and psychological consequences of dieting result in a loss of control over restraint (Herman & Polivy, 1984). This results in binge eating, where an abnormally large amount of food is consumed in a short period of time. Bingeing leads to the possibility of weight gain and purging occurs to prevent this. Bingeing and purging behaviours typically act to lower self-esteem, completing the vicious cycle of bulimia nervosa. For more detail on the cognitive model of bulimia the reader is referred to the work by Fairburn and his colleagues (Fairburn, 1981; Fairburn, Marcus & Wilson, 1993; Wilson, Fairburn & Agras, 1997).

The cognitive behavioural treatment (CBT) for bulimia nervosa is based on the model outlined above, and is divided into three stages. In the first stage (six sessions over three weeks) primarily behavioural techniques (self monitoring, weekly weighing, prescribing regular patterns of eating, self control strategies) and psychoeducation are utilized. Sessions nine through sixteen focus on eliminating dieting, teaching problem solving skills and cognitive restructuring. Cognitive restructuring focuses on modifying the over-concern with weight and shape as a component of self-esteem. Body image distortion is dealt with in this stage (see below for an elaboration of cognitive behavioural techniques in the treatment of body image). The final phase comprises two sessions at second weekly intervals and focuses on relapse prevention strategies. Currently, this form of manualised CBT is considered the first line treatment for bulimia nervosa. In clinical trials it has proved superior to other psychological interventions and anti-depressant medication (for a review see Wilson et al. 1997). The reader is referred to Fairburn et al. (1993) and Wilson et al. (1997) for more information of CBT for BN.

Cognitive behavioural treatment of anorexia nervosa is more complex than bulimia nervosa. Therapy must address issues of motivation in treatment, the need for weight gain, and generally incorporates aspects of interpersonal therapy and family therapy (although see Fairburn et al. 1999). It is recommended that treatment continue for at least one year (Garner et al. 1997). The initial phase of treatment focuses on the establishment of a therapeutic alliance with the patient. Given the resistance of patients with anorexia to relinquish their drive for thinness, the establishment of a trusting therapeutic relationship takes considerable time at the initiation of treatment, and the state of the alliance requires constant monitoring during treatment. Motivational interviewing techniques are important at this stage of treatment (Treasure & Ward, 1997; Vitousek, Watson & Wilson, 1998), particularly the expression of an understanding of the psychological function that anorexia plays in the individual's life.

Once motivation for change has been established, therapy focuses on restoring normal nutrition and weight gain. Again, behavioural strategies (self-monitoring, weekly weighing, introduction of a regular pattern of eating, gradual exposure to eating larger meals and avoided foods) are used. Strategies, particularly anxiety management techniques, to cope with the distress this causes are also taught at this stage, as are techniques to disrupt any bingeing or purging behaviours. Cognitive techniques in phase one focus on helping the patient challenge their automatic thoughts about eating, weight and shape.

The second phase of treatment emphasizes cognitive restructuring of food and weight related themes. One manual (Garner et al. 1997) then suggests a broader emphasis of cognitive treatment focusing on modifying self concept, increasing self esteem, raising awareness of affect and teaching the expression of emotions, as well as an increased interpersonal focus in therapy, including family therapy. A more recent paper on the cognitive theory of anorexia (Fairburn et al. 1999) questions whether the focus of therapy needs to be so broad, and suggests that cognitive restructuring is focused on the excessive need for self control through weight control.

As in BN, the final phase of treatment is relapse prevention, which focuses on reviewing the fundamentals of treatment and highlighting areas of future vulnerability. Identifying conditions under which the patient should return to treatment is also an important part of relapse prevention. More detail of CBT for Anorexia Nervosa can be obtained from Fairburn et al. (1999), Garner et al. (1997) and Kleinfield et al. (1996).

There is little empirical evidence about the effectiveness of CBT in AN. There are only eight controlled studies for the treatment of AN that fall within the medium to high quality range of outcome studies (Ball, 1998). Only two small controlled treatment studies (Ball, 1988; Channon, de Silva, Helmsley & Perkins, 1989) have directly investigated CBT for AN and the results have been equivocal. Despite this, a survey of clinicians at major eating disorder conferences in 1988 and 1990 indicated that 90% of clinicians considered CBT to be an integral part of treatment for AN (Herzog, Keller, Strober, Yeh & Pai, 1992).

Psychological features of body image disturbance (BID)

Body image is the picture that we have in our minds about the size and shape of our bodies (Slade, 1982), but it also involves wider dimensions such as how we think and feel about our body and the importance that we place on appearance in our lives. The disturbance of body image is a characteristic feature of eating disorders, at least in Western cultures (Lee, 1993). Body image disturbance in eating disorders consists of a number of clinical features (Rosen, 1997).

Cognitive dimension

Cognitively, people with BID think about their bodies in negative ways. Rosen (1997) refers to this as 'negative body talk'. This can be about their body in general ('I'm fat') or about specific body areas ('My thighs are too fat'). Numerous cognitive distortions act to maintain BID. These include biases in information processing (Butlow, Beumont, & Touyz, 1993) and thinking errors such as dichotomous reasoning (viewing themselves as either thin or fat) and selective attention to the features of their body they perceive as too fat, whilst ignoring other aspects of body image. One patient described her cognitions as she viewed her body in the following way:

> *I looked at myself in the mirror and did not see myself. I was like an artist looking at a sculpture. I would constantly look for what was wrong and what I needed to fix. I was my own major work.... I could never be happy with the sculpture; I would only focus on what needed to change. I was never thin enough and what was not thin was therefore fat. When I couldn't find any fat I would just think myself fat.*

This client describes poignantly the process of selectively viewing negative parts of her body, dichotomous reasoning, and the feeling of disconnection with the body experience that people with AN often describe.

Another cognitive feature of BID in the eating disorders is the constant preoccupation with thoughts of weight and shape. These thoughts are frequent, intense and typically intrusive in the client's life. Indeed, most patients presenting for treatment of an eating disturbance will list the constant thoughts about food, weight and shape as a primary motivation for change. The intensity and intrusiveness of the thoughts is comparable to thoughts experienced by those with obsessive compulsive disorder (Thornton & Russell, 1997). As described above, people with eating disorders place excessive importance on weight and shape in terms of self worth and self-concept. This is a central cognitive feature of BID in eating disorders.

Affective dimension

Body image disturbance also has a significant affective dimension. Body image has been shown to become more distorted by negative mood (Taylor & Cooper, 1992), by events such as consumption of high calorie food (Thompson, Coovert, Pasman & Robb, 1993), by seeing thin media images of women (Hamilton & Waller, 1993), and by menstrual status (Carr-Nangle, Johnson, Bergeron, & Nangle, 1994). It is suggested that these situations influence BID through the induction of negative mood. A clinical example that illustrates the effect of negative mood on BID that I tell to my patients is of a 21 year old patient with restricting AN who had been re-fed as an inpatient from a body mass index (BMI) of around 14 to 19. She reported to me in the afternoon that, although she was unhappy with her new shape, she was accepting of it and did not think or feel that she was fat. During a family visit there was a degree of interpersonal conflict between the patient and her father. Following this, the client returned to a subsequent session full of hatred toward her body and both thinking and feeling that she was fat. She was able to note that the change in her attitude to her body was linked to the interpersonal conflict and understand that her body image was strongly influenced by interpersonal conflict and negative affect.

One interesting affective aspect of body image is the phenomenon of 'feeling fat' as opposed to 'thinking fat'. Touyz, Beumont & Collins (1988) found that asking patients how they felt they looked produced significantly greater body image distortion than if patients were asked to display how they thought they looked. This discrepancy has been reported to result in the under-diagnosis of eating disorders by structured clinical interview (Thornton, Russell & Hudson, 1998).

Behavioural dimension

A third feature of BID is the behavioural mechanisms of hyper-vigilance and/or avoidance of information concerning weight and shape (Fairburn et al. 1999; Rosen, 1997). These behavioural features are central to the cognitive behavioural account of the maintenance, and treatment, of BID in the eating disorders. As described above, a core cognitive feature of BID is the belief that the body is too large. This perception leads to continual 'body checking' behaviour. This may include taking 'skin folds' with their fingers, checking oneself repeatedly in the mirror, repeated weighing, seeking reassurance and comparing themselves to other women. Hyper-vigilance with the body also acts to maintain BID by interacting with confirmatory information processing (Fairburn et al. 1999). For example, a person with AN feels fat, checks her body for the presence of fat, and finds fat (often whether it is there or not), which confirms her belief that she is fat. This maintains the distortion of the body image. These distortions are likely to be even more exaggerated by the experience of negative affect (i.e. the affective feature of BID). Negative affect increases body checking which leads to more negative affect and more checking, each continuing to act to reciprocally maintain the other.

As the vicious cycle of checking shape and weight becomes aversive, the affected person may avoid looking at her shape or refuse to be weighed. This will provide some relief from the presumed knowledge that she is 'fat', but overall her anxiety will be maintained as she now lacks any disconfirmatory evidence that she is not 'fat'. The lack of disconfirmation enhances the perception of being 'fat' which results in increased efforts to control weight and shape. Many people with eating disorders will engage in avoidance behaviour such as avoiding social situations, avoiding their image in mirrors, wearing clothes that hide their figure ('fat clothes') or grooming themselves so as to distract from their appearance. For example, a recent client (of the second author) described how early in her therapy she benefited little from our sessions, as she was focused on how to sit with a male therapist so that I would not notice how 'fat' she was.

Perceptual dimension

Over 50% of people with eating disorders experience their body as larger than it is (Collins, Beumont, Touyz, Krass, Thompson & Phillips, 1987), although some underestimate their body size (Touyz, Beumont, Collins, McCabe, & Jupp, 1984). This process is not well understood and its usefulness as a clinical feature of BID has been questioned (Rosen, 1997). It may reflect a neurological basis of BID (Lacey & Birtchnell, 1986). However, the perceptual disturbance typically only relates to the individuals own body, and not to the way the bodies of others are perceived. This indicates that psychological processes are more central than any neurological process.

Cognitive-behavioural strategies in the treatment of body image disturbance

The treatment of body image is significantly under-emphasized in the treatment literature on eating disorders. One reason for this may be that body image disturbance and over-concern with weight and shape have often been seen as refractory to treatment, and have often been construed as a symptom which recovers naturally after normal eating has returned (Touyz et al. 1988). However, reports of treatment programs that successfully modify other aspects of eating behaviour often fail to modify body image concerns. Rosen (1997) cites several follow up studies of people with eating disorders who restored body weight, and ceased disturbed eating behaviour, but where a significant number still worried excessively about weight and physical appearance.

A variety of strategies have been described in the literature for the treatment of body image distortion. An emphasis is made in this section on cognitive behavioural strategies, as these have been the most clearly outlined in the literature and empirical support has been found for their effectiveness (Rosen, 1996; Rosen, Cado, Silberg, Srebnik, & Wendt, 1990). This section of the chapter assumes that the clinician has experience in the cognitive model of psychopathology and in the use of cognitive restructuring and exposure based treatment. Some of the techniques described below would be considered advanced cognitive behavioural therapy, and should not be undertaken by those without appropriate clinical training and experience. Exposure tasks, if not completed correctly, can re-sensitize the person and make body image more, rather than less, disturbed. If the reader does not have the appropriate training, the techniques should be applied only under appropriate supervision (eg a Clinical Psychologist) or the patient should be referred to an appropriate practitioner. Furthermore, it is not useful to apply these techniques in isolation from a collaborative and empathic therapeutic relationship. The primary strategies that are outlined below are 1) Psychoeducation, 2) Exposure and response prevention, 3) Cognitive restructuring, 4) Size estimation tasks, 5) Increasing pleasurable body experience.

Psychoeducation

This is described more fully earlier, but this discussion outlines specific issues with respect to BID. From the perspective of BID, education about body image, and weight and shape malleability can be used in the early stages of therapy. Clients may have distorted views about what features of their bodies can or cannot be changed. For example, the belief that complete and utter control over weight and shape change is possible is a major source of body image distress for such people. Education about set point and genetic influences on weight and shape can be helpful to present to the clients especially if it is presented in an age-appropriate form (Garner, 1997). The idea that weight loss does not alter a genetically determined body shape needs to be emphasized. People with BN need to be educated in the biological limits of weight loss and the relationship between dietary restraint and bingeing. Again, psychoeducation and guided self-help manuals can be helpful here (Fairburn 1995).

Clearly, another focus of psychoeducation in this domain is education about the influence of Western views of femininity and the resultant effect on 'ideal' shapes. Discussion of how eating disorders in Asian countries do not necessarily experience a distortion of body image as a result of less exposure to Western culture (Lee, 1993) may be useful. However, some clients may try to overestimate the role of society in their own eating disorder. It is important to highlight to the client that all women are exposed to these images, and eating disorders, at least in their full clinical presentation, are a relatively rare condition. People who develop eating disorders and those who do not are equally exposed to these images and messages, yet the former group may pay more attention to the messages (Griffiths, Beumont, Russell et al. 1999; Murray, Touyz & Beumont, 1996). The personal meaning of these messages is an important target for cognitive restructuring.

As discussed earlier, although there is some evidence that merely providing psychoeducation about BID is helpful for some people with eating disorders, it is clearly not enough treatment in of itself for the majority. Simply giving a person with an eating disorder something to read and discuss is unlikely to be effective, especially if the diagnosis involves AN. Psychoeducation ignores the complex process and motivational issues in anorexia nervosa (Leung, Waller, & Thomas, 1999), and the significance of this can never be underestimated in the management of eating disorders.

Exposure and response prevention

There are clear similarities between the body checking, hyper-vigilance and avoidance processes that maintain BID in eating disorders and processes that maintain Obsessive Compulsive Disorder (Fairburn et al. 1999). These similarities have clear implications for treatment. As exposure and response prevention is clearly the psychological treatment of choice in OCD (Steketee, 1993), exposure techniques play a central role in the Cognitive Behavioural Treatment of BID.

A central form of exposure is mirror exposure (Rosen, 1997; Tuschen & Bent, 1996). As in the treatment of anxiety disorders, the client is encouraged to confront the feared stimulus (the image of their body) in a mirror in such a way as to allow the distress associated with seeing their image to decrease. Clients should first be educated about how their avoidance or negative scrutinizing of the body acts to maintain their eating disordered thoughts (ie educated in the cognitive model of BID). Together, client and therapist should construct a hierarchy of confronting body images based on a thorough assessment of behaviours that maintain the BID. The client is then encouraged to complete a series of exposure tasks, first in session and then at home. These might start from completing tasks in clothes the client feels most comfortable in (often excessively baggy) and working towards wearing the fuller range of clothes the client has increasingly avoided because of intense concern about body shape or weight (eg shorts or swimsuits). Stimuli known to increase BID, such as negative affect (Taylor & Cooper, 1992), eating (Thompson et al. 1993), viewing magazine images (Hamilton & Waller, 1993), and menstrual status (Carr-Nangle et al. 1994) should be included in the hierarchy. In conjunction with working through this hierarchy, clients should be asked to self-monitor times when they experience more intense anxiety about their body weight and shape, and if appropriate, these should be incorporated in the exposure hierarchy.

Whilst conducting these activities of treatment, efforts should be made to help the client detect and manage automatic thoughts. Clients should be encouraged to adopt a 'mindful' (Linehan, 1993) attitude towards their body, focusing on description and acceptance without judging. This task is invariably difficult for the person with an eating disorder, as it is for many women expressing even mild dissatisfaction with weight and shape. Nevertheless, the therapist should encourage the client to relax, perhaps by using a modified relaxation script, whilst learning to tolerate her body and foster the use of non-judgmental language in relation to it. As is the case with all exposure-based psychological treatments, the client is in control of continuing or discontinuing the exposure, and should be reminded that discontinuing an exposure before 'habituation' of anxiety may result in a heightening of the client's belief that her body is an intolerable source of distress. Habituation is a technical term which, in this case, refers to the reduction in the intensity of anxiety symptoms following anxiety-provoking stimuli.

Many clinicians would have concerns about incorporating the use of mirror exposure into their practice. As mentioned at the beginning of this section, exposure techniques should only be used by clinicians with a thorough understanding of the principles of learning theory and exposure. However, the concerns about these exposure techniques are likely to run deeper than theoretical disputes between treatment models. Namely, not all clinicians agree that male therapists working with female clients should use these techniques (Katzman & Waller 1998; Zunino, Agoos & Davis, 1991). Exposure and response prevention techniques involve asking (usually) young women to wear more revealing attire for some treatment tasks, and the effect of this on the client, the therapist, and the therapeutic relationship must be carefully considered and monitored. Ultimately, clients never should be put in a position where they feel the situation is unsafe or beyond their control. Furthermore, the speed of exposure treatment must also remain with the client and it is advisable to be conservative in the construction of exposure hierarchies.

A further caution concerns the use of mirror exposure in the case of clients with a history of trauma, particularly sexual abuse. A number of clients will have been sexually, emotionally and physically abused (Brown, Russell, Thornton & Dunn, 1997) and mirror exposure work with such people poses the risk of re-traumatisation. While a clinician can inquire about a history of trauma, the process of disclosure of abuse is complex and not all will disclose a history of trauma even if asked directly by a sensitive clinician (Brown, Russell, Thornton, 1999). However, as stated by Rosen (1997), *sexual abuse history is not a contraindication for body image therapy* (p.192). A cost-benefit analysis of including mirror exposure work should also note that, as yet, no comprehensive empirical evidence suggests that adding these techniques will improve outcome. Nevertheless, mirror exposure is advocated by some (Rosen et al. 1990) as central to the effective treatment for BID (Rosen et al. 1990).

Other exposure techniques form an important component of CBT models of treatment of BID. The hypervigilant and avoidant behaviours described above which serve to reinforce and maintain BID should be prevented. Body checking will often respond to increased awareness and self-management programs. Furthermore, clients should be encouraged to refrain from weighing themselves between sessions, and the advantages and disadvantages of frequent weighing should be discussed. Ultimately, the goal is to help the client have an understanding of the self-defeating nature of checking/monitoring behaviours, and highlight the advantages of a decreased focus on weight and shape. 'Worry exposure' is a technique used in the treatment of other anxiety disorders (Craske, Barlow & O'Leary, 1992) and this may also be useful in the treatment of the cognitive preoccupation with shape and weight (Wilson, 1999). Here, clients are asked to focus on the thought and to generate anxiety-provoking images associated with the thought according to a predetermined hierarchy. This focus should continue until habituation occurs.

Cognitive restructuring

As with all cognitive behavioural treatments, self-monitoring of cognitions (eg through a diary) about body and shape issues should be encouraged. Initially, negative descriptions often prevail ('I have fat legs'), but therapists should attempt to elicit the personal meaning, or perceived consequences of having such views. For example the therapist may ask the question 'what does it mean to you that you see yourself as having fat legs?' Often this will reveal a perceived connection between a body defect and the perceived belief of a personal defect (Rosen, 1997). For example 'If people notice how fat my legs are this will reveal how lazy and unlovable I am'. This belief can be challenged at two levels. Initially, cognitive restructuring should be aimed at the level of negative body talk 'my legs are fat'. The generation of more neutral and less pejorative descriptions of their body becomes a treatment task. This is similar to the technique of 'mindfulness' described earlier (Linehan, 1993). These more neutral descriptions should be rehearsed during the mirror exposure sessions and at home. Kerney-Cooke and Striegel-Moore (1997) suggest the use of a log for clients to record positive feedback about their bodies. This technique aims to counteract the selective negativity of the eating disordered person. As an extension of this, the client could be asked to practice, perhaps initially through role-play, not discounting and then accepting, compliments. Subvocal rehearsal of compliments may be helpful in some cases (Rosen, 1997).

The second level of cognitive restructuring involves examining and then challenging assumptions connecting body shape to aspects of personal values or self worth. Here standard cognitive techniques may have more difficulty: of course, many such assumptions are powerfully sanctioned and reinforced by cultural and social forces. Asking a female to list evidence that worth is connected to appearance is typically an unhelpful question, since many facets of society endorse this view. In people with eating disorders, particularly in anorexia nervosa, the connections between weight/shape and self-concept are dramatically more powerful, and this renders efforts to restructure such views as extremely problematic. Indeed, Vitousek et al. (1998) suggest that the veracity of these cognitions in people with eating disorders makes evidence about the correctness or validity of these belief irrelevant and largely unavailable to the client. Rather, it is suggested that cognitive restructuring focuses on the advantages and disadvantages in terms of physical, emotional, cognitive and relational areas of holding the belief that thinness is all important, whilst validating the conflict that the client must have in a society that compels her to desire extreme thinness. This reduces resistance to the challenging of the core belief and helps the client understand the effects of holding such strong yet distorted beliefs.

Size estimation tasks

Size estimation tests are frequently employed to modify distortions in body size. Such tests include drawing real and perceived body outlines, asking the client to estimate how much a door needs be opened for her to fit through in profile. Exercises such as these provide the client with objective and immediate corrective feedback regarding the discrepancy between real and perceived body size. However, it should be noted that these techniques have been shown only to rectify size estimation distortion (Goldsmith & Thompson, 1989), and have no meaningful effect on modifying body dissatisfaction (Ferandez & Vandereycken, 1994). Further, these tasks have not been shown to add to the efficacy of an overall cognitive behavioural program for body image distortion (Rosen et al. 1990).

Despite these findings, it is still argued that size estimation tasks are useful in raising insight into the process of body image distortion (Rosen, 1997). Such insight can be combined with cognitive tasks such as reattribution. Use of analogies may be helpful to illustrate such processes. For example, it could be suggested to clients that they view their perception of their body as though they had colour blindness (Garner, et. al, 1997). It is suggested that colour blind people learn not to trust or base everyday decisions on their júdgement of colour (eg in making decisions about going through traffic lights). Similarly, people with eating disorders should not base decisions, such as a desire to seek further weight loss, on their perceptions of their body.

Increasing pleasurable body experiences

Along with modifying negative aspects of body image, efforts should be made to increase the experience of pleasurable body experiences (Rosen, 1997; Vandereycken et al. 1992). Such efforts may include activities such as breathing, massage, movement and sensory awareness training, or even dance therapy. Exercise and weight training have also been used to increase connection to the body, experience the body as effective and improve body image in people with anorexia nervosa who are gaining weight (Beumont, Beumont, Touyz, & Williams, 1997). Guided imagery can also be used to develop an alternative view of the body (Kearney-Cooke & Striegel-Moore, 1997).

More general techniques: Body orientated therapies

Other techniques, such as 'Body Oriented Therapy' (Probst, van Coppenolle & Vandereycken, 1995) are also described in the literature. This includes therapeutic techniques such as relaxation and breathing exercises, massage, role-plays, psychodrama, physical sports and games, dance and creative movement, sensory awareness training, and guided imagery. These techniques are described in detail elsewhere (Probst et al. 1995) but their efficacy has not been empirically evaluated.

Expanding self-concept

Many people with eating disorders describe that their body image over-concern and dissatisfaction decreases upon improved self acceptance and self esteem. Irrespective of theoretical orientation, most therapists working with eating disorders aim to increase their client's definition of themselves through means other than weight, shape, and appearance, and develop a more comprehensive view of self. It is useful to help such people identify others they know to whom the rule 'thinness equals success, beauty, control and power', does not apply. For example, 'do you know people that you admire who do not conform to the thin ideal? Do you know people who do conform to this ideal yet who are not happy or do not seem in control? Clients should explore the constructs by which they value others and begin to consider if their closest relationships are based on physical appearance or wider constructs. These techniques, and others that act to increase self esteem (communication training, assertiveness, problem solving, emotional regulation etc), are likely to indirectly effect body image distortion.

In sum, body image preoccupations and disturbances fulfil specific and central functions for people with eating disorders, although the function and meaning may differ between clients (Jarry, 1998). Functions pertinent to each case may have slightly different implications for preferred techniques chosen in treatment. Little is known about the function and meaning of BID in men with eating disorders, and this along with the efficacy of many treatment techniques, awaits further systematic investigation.

Summary recommendations

Eating disorders are complex phenomena, and any causal theory or advocating a unidimensional explanation or treatment pathway must be treated with considerable caution. The field of eating disorders poses special issues and challenges for health professionals and health settings in the delivery of treatment. Furthermore, while there has been a dramatic surge of clinical, research, public, and media interest over the past 20 years, the knowledge and attitudes about eating disorders amongst health professionals remains a source of concern. The provision of ongoing education, development of guidelines for clinical practice and access to clinical supervision/peer review are important means by which these difficulties can be addressed.

In anorexia nervosa, empirical evidence has yet to be developed regarding the definitive superiority of one type of treatment over another. Expert opinion and professional practice guidelines concur that treatment is better than no treatment at all, and that certain treatments should be offered in certain broad sequences.

There is evidence to suggest that Cognitive Behavioural Therapy is an effective treatment of bulimia nervosa and body image disturbance and should be offered to those suffering from this disorder. Given the scarcity of treatment provision, it is inevitable that most cases will be managed by non-experts. While some forms of treatment can be delivered by non-experts, other psychological techniques should be used (or supervised) only by a health professional with relevant clinical training and registration. Often, this will be Clinical Psychologists. In Australia, Clinical Psychology is not covered by the Medicare Schedule and is poorly covered by private health insurers. This often means that sufferers of eating disorders are prohibited by cost from receiving the appropriate treatment. Access to psychological services should be reviewed as a policy priority. Effective psychological treatment usually requires attendance not only to symptom resolution, but also attendance to underlying psychological structures at an individual level.

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Chapter 13 – In-patient Care from a Nursing Perspective

Peta Marks

Caring for patients with eating disorders can be one of the most challenging and rewarding specialties within mental health nursing, but for some nurses it is frustrating, anxiety provoking and emotionally draining. Even for the most experienced clinician, these dichotomies can and will exist, seemingly simultaneously at times, and nurses must be aware of the potential for burnout and/or emotional over-or-under-involvement.

Nurses become many things to a patient suffering an eating disorder, most essentially someone who is familiar with the person's feelings, ideas, emotions, routines, rituals and behaviours. Nurses need to be skilled in recognising and interpreting the physiological and psychological signs, symptoms, and complications of these disorders. It is imperative to develop an empathic non-judgemental approach, and maintain clear professional boundaries. Yet the nurse's job is to challenge fixed and unrealistic beliefs and assist in the development of motivation to change, so it is necessary to form a strong and trusting bond. As well, nurses provide information, act as role models and support the patient and family through the recovery process. Consequently, nurses need education, clinical supervision, support from management and administration, collaboration and communication with other professionals and nursing colleagues, and recognition from other members of the treatment team that their role is valuable and can make a vital contribution.

Nurses specialising in eating disorders and professional isolation

In Australia to date, there have been no uniform structures, policies or best practice guidelines for the development of eating disorder services. This has impacted on the nursing profession because styles of clinical management have evolved largely in isolation. The relative paucity of published nursing research or professional debate about the management of eating disorders, may be evidence of the lack of communication between nurses across treatment centres. This becomes apparent when compared with other health professions in the eating disorder field, namely psychology and psychiatry, where for some time, clinicians have been working together conducting research, developing treatment and prevention programs, and publishing their ideas, comments and discussions, as well as interacting in national and international forums to share their knowledge and experiences.

Specialising in caring for patients with eating disorders is not generally seen as an attractive career direction within mental health nursing. This is largely because these patients are seen as being complicated to care for, manipulative and difficult (Lindsay, 1997). Research indicates that nurses begrudge caring for patients who appear to have self-inflicted problems because they utilise valuable resources and are somehow seen as being less deserving (Franko & Rolfe, 1997). As well, people severely ill with eating disorders display *marked personality changes mimicking primary personality disorders* (Garner & Garfinkel, 1997, p:102), may be cognitively impaired, and are frequently severely and physiologically compromised: symptoms that may dissuade some nurses from wanting to work with these patients. It also seems incomprehensible to many people that anyone could have a problem with the simple act of nourishing one's body. We have all heard (and probably at some time all said) something like 'why can't they just eat?'

For nurses working with eating disordered patients, particularly those in small units, lack of support and understanding from colleagues and the difficulty of establishing networks for sharing ideas and issues makes developing new ways of approaching problems and maintaining empathy difficult. It is only recently that nurses have started to seek each other out to discuss the evolution of specialised nursing management by comparing programs, discussing philosophy and approach, attending conferences, and participating as nursing specialists in professional forums. Muscari (1998, p:130) states that *nurses can and do care for adolescents with anorexia and bulimia. All it takes is commitment, knowledge, and networking.*

A centre of excellence, employing mental health nurses with interest and expertise in eating disorders would provide nurses with professional support, opportunities to develop best practice, and opportunities for nursing research. It would also enable strategies to be developed in an ideal professional environment to address the more common problems nurses face, such as lack of consistency between staff members in maintaining a successful refeeding program.

The role of the nurse

It is familiarity with the person, their behaviors, thoughts, concerns, issues and feelings that makes the primary nurse a most influential and important professional providing care to the patient with a eating disorder. The role of the nurse is varied and includes:

1. Facilitating the development of a trusting rapport between the patient and the treatment team.

2. Closely monitoring the patient's physical and mental status.
3. Establishing and maintaining a flexible yet structured milieu, ensuring all nursing staff develop and practice from a common philosophical approach.
4. Acting as an educator, role model, group facilitator, support person and frequently, the voice of reason.
5. Setting limits and maintaining personal and professional boundaries without compromising the therapeutic relationship.
6. Taking on the role of multi-disciplinary treatment team coordinator.
7. Engaging in self-reflection and clinical supervision, providing education and support for nursing staff and ensuring that communication between staff members occurs frequently as a matter of course.
8. Maintaining comprehensive nursing records and management plans.

Facilitating rapport between the patient and the treatment team

In order to promote trust between the patient and the treatment team, the nurse must first develop a therapeutic relationship with the patient. The following process will probably be included: familiarising oneself with the patient's thoughts, feelings and behaviours; understanding as far as possible the individual's anorexic experience; aligning oneself with the patient against the disorder; and displaying an empathic, non-judgemental but structured approach. Being willing to spend time listening to the person, really wanting to understand how the experience is for them, and communicating genuine interest in and acceptance of the person, their needs and priorities, are essential parts of this process.

The essence of mental health nursing is the development of the therapeutic relationship, and it is of prime importance in nursing patients with an eating disorder. In the 1950s, nurse theorist Hildegard Peplau stated that, *Nursing is a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals in communities* (Doheny, Cook & Stopper, 1992, p. 45).

Familiarity

Patients spend more time with nurses than they do with any other health professional. They allow nurses to experience them in a more 'natural' state than that presented during an appointment, a brief encounter or during a case review. A period of hospitalisation is, in this respect, a shared, lived experience for both the patient and the nurse.

In some ways the nurses' experience is similar to that of families/carers, particularly when hospitalisation is prolonged (as it tends to be in anorexia nervosa). The patient becomes familiar to us and with us. We see them in pyjamas first thing in the morning, we see them when they are frightened and angry and hungry. We learn to anticipate emotional and behavioural responses to various situations; we know what a certain 'look' on the face means, as well as how they feel about parents, the future and the self.

Understanding the experience

The nurse who can help a patient with an eating disorder will understand what it means to have the disorder. Much like a 'profiler' in a crime story, the nurse needs to understand the experience the person is living, before that person will let the nurse assist. *The fact is that we cannot expect our patients to listen to us if we do not understand their experience, if we do not understand why we are being resisted* (Bemis-Vitousek, 1998, p. 10). First and foremost, nurses must become familiar with the aetiology, signs, symptoms and behaviours associated with starvation. It is usually those nurses who have a fragmented or 'magazine-level' understanding of the psychological and physiological complexities of the eating disorders, who find nursing these patients difficult and who subsequently manage them poorly.

The controversial Minnesota experiment, published by Ancel Keys and associates in 1950, highlighted the fact that many 'features' of anorexia nervosa are in fact physiological and psychological manifestations of the state of semi-starvation. The study, or a brief version of it, as can be found in Garner and Garfinkel's *Handbook of Treatment for Eating Disorders* (1997), is essential reading for any nurse who wants to understand the bio-psycho-social ramifications of starvation or semi-starvation, and particularly how this applies to anorexia nervosa.

The nurses' knowledge of these aspects of the eating disorders also benefits the nurse-patient relationship. When one realises that most of the 'disturbances' apparent in patients with anorexia nervosa – abnormal eating behaviours; furtive exercising or purging; argumentativeness, belligerence or angry outbursts; ambivalence and guilt associated with gaining weight; and intense preoccupation with thoughts of food and eating – are sequelae that were evident in the group of 'normal' men who participated in the starvation experiment, it becomes easier to view the behaviours, the disorder and the person as distinct entities. Sound knowledge of the disorders and their effects is essential, as research shows that patients find *those with expert knowledge of eating disorders more helpful than those without such knowledge* (Yager in Lindsay, 1997, p. 905).

Approach – with the patient against the disorder

Clinical experience teaches us that the most effective way a nurse can engage a patient and help her/him to give up attachment to the eating disorder, is to establish, first and foremost, that the nurses' role will be to work with the patient against the disorder.

If the nurse takes a patriarchal, authoritarian approach, telling the patient how to go about the business of eating, then that person is establishing themselves and their role in opposition to both the patient and the disorder. This will only drive the patient to cling more ferociously to the most reliable communication tool and defence mechanism she/he has – not eating.

Patients with eating disorders need to be managed sensitively and it is important to consider the profound impact starvation has on cognition, emotion and behaviour. 'Sensitively' does not mean without structure, or without boundaries, or without limits. It means that the approach the nurse uses must be well calculated. A careless comment or a frustrated tone of voice can impact negatively on the nurse-patient relationship and drive the patient to seek comfort in their disorder. However, it is also true that making errors of judgement, saying things without thinking and not being 'perfect' all of the time are human processes – and that the nature of 'humanness' is something worth discussing with patients who have eating disorders. After all, the standards by which they judge themselves are almost always more stringent and unrealistic than those they impose on others.

Empathy

Kelly Bemis-Vitousek (1998) says of empathy that *it does not come automatically or easily* (p10). She outlines four important features or principles she uses to sensitise 'novice therapists' to eating disorder patients. These are: to appreciate the fully egosyntonic nature of thinness and self control; to recognise the desperation that drives symptom 'choice'; to avoid attaching surplus meaning to resistance, by remembering that more often than not, patients with anorexia nervosa have not asked for help; and to acknowledge the difficulty of change (Bemis-Vitousek, 1998, pp. 10-12).

Monitoring the patient's physical and mental status

Because anorexia nervosa presents us with an intertwined combination of physiological and psychological complications, which are frequently sequelae of one other, an important function of the nurse's role is to monitor the physical and mental status of the patient.

There is a significant risk of death in anorexia nervosa. Mortality rates have been estimated at 20% at 20-year follow-up (Beumont et al. 1995). Consequently nurses must be vigilant for signs and symptoms that may indicate serious or potentially fatal complications. There are several key physiological abnormalities that the nurse must be aware of and monitor for – most particularly the presence of refeeding syndrome, delirium, cardiac complications or renal failure (Beumont et al. 1993).

Refeeding syndrome is a complex and potentially fatal condition of severe fluid and electrolyte shift associated with *the administration of energy and substrate in excess of the amount required to maintain metabolic homeostasis* (Chwals, 1994). A review of the literature by Corley (1999) identified the primary metabolic features of the syndrome as hypophosphatemia, hypokalaemia and hypomagnesaemia, and the clinical signs and symptoms of note to include delirium, arrhythmia, cardiac failure or acute myocardial infarction and sudden death. It is essential that nurses caring for patients who are being naso-gastrically fed are aware of the physiological processes involved with refeeding and the potential for complications. Routine observations are essential and distinguishing between the 'usual' pathological signs of anorexia nervosa (bradycardia, hypotension, arrhythmias, hypothermia) and the 'unusual' pathological signs of refeeding syndrome will require close attention.

Osteoporosis, osteopaenia, dehydration, hypothermia, and neurological complications (seizure, peripheral neuritis) are also problematic in patients with anorexia nervosa – as are less severe (but at times more disturbing for the patient) problems with constipation, cramps, nausea, dental caries and enamel erosion (Beumont et al. 1993). The nurses' role is to monitor the patient's physical status and, where possible, minimise discomfort, in order that progress is not adversely affected or impeded by the disease sequelae.

The patient's mental state must also be monitored closely. While patients with anorexia nervosa commonly display low or labile mood, poor concentration, disrupted sleep patterns, impaired memory and obsessive compulsive features, the nurse needs to be constantly assessing for signs that may indicate that a secondary diagnosis of clinical depression or obsessive compulsive disorder is warranted. As well, the nurse will need to be aware of the cognitive impairments affecting the patient's capacity to absorb new information. Accordingly, psychoeducation and counselling will need to be individually tailored to suit the patient's strengths and weaknesses.

Establishing a therapeutic milieu and a common philosophical approach

> *The therapeutic milieu is essential to the operation of inpatient… units and nurses are the professional group responsible for instituting and maintaining this environment, yet their specific functions are vaguely stated and often intuitively defined* (Creedy & Crowe, 1996, pp. 85-86).

In an eating disorder unit the 'specific functions' of the therapeutic milieu include flexibility within structure, and a consensus between staff members regarding the unit's philosophical approach. Although every nurse has a different personality and style of nursing, it is important that all staff agree on the overall goals and direction of the program. This enables individual nurses to work flexibly within the structure of the program, and reduces the potential for nurses to become bogged down with the procedural details at the expense of the bigger therapeutic picture.

For example, a program procedure may be that nurses sitting with patients during meal times encourage the patient to abstain from abnormal eating behaviours. A nurse who challenges a patient about such behaviours while sitting at the table, without first discussing the behaviour with the patient and developing a 'plan of action' away from the table, is not acting in a way that suggests he/she is a supportive and helpful professional whose goal is to help the patient learn how to get better in the least stressful way.

Nurses new to the eating disorder program should be carefully inducted and given ample clinical supervision and support, particularly in the early stages of their initiation. If this does not occur, they are likely to fall into the trap of becoming 'program orientated' rather than patient orientated, thus increasing the potential for countertransference issues becoming problematic and undermining the overall strength of the program.

Educator, role model, group facilitator, support person – the voice of reason

Most patients will have varying levels of understanding of their illness and its direct effects on their thoughts, feelings and behaviours. Nurses should not assume that because a patient sounds knowledgeable that they are not in need of information – a patient's knowledge may be inaccurate, or applied incorrectly. For example 'Dietitians say that fat is bad for you. If less fat is good, then no fat must be best. I want to be healthy, so I choose not to eat fat. If I eat fatty foods, I am just going to put on fat'.

Nurses must also take on the important role of working with the patient's family. Understanding the machinations of the family will assist the nurse in understanding the patient. Through discussion with family members, we can gain insight into the patient's strengths and weaknesses, how the disorder is used to communicate and how it impacts on family dynamics. It will also benefit the patient if the nurse can help the family to cope with the illness and its effects. Of course, the patient is always the nurse's primary concern and issues of confidentiality must be considered. Nurses would do well to seek the patient's permission before speaking with the family, or instead, involve the patient in family discussions. In addition, discussing with the patient the variety of roles that nurses may assume, will give them the opportunity to elicit help and support in family discussions.

As well as developing and sustaining individual relationships, nurses must act as group facilitator for all patients on the program. Relationships between patients can deteriorate rapidly and group dynamics will require close attention. Some patients will act as an inspiration to others, providing support and a sense of experiential understanding. At other times, patients may vie for the nurse's attention, compete with each other, and undermine one another's self-confidence and therefore the potential of the program to help. It is not uncommon for 'good' and 'compliant' patients to feel resentful and ignored when a new or demanding patient absorbs nursing time. The nurse's distraction may be interpreted as an indication that her/his problems are less important and that the other patient is sicker or more worthy of attention.

It must be remembered that by setting out to develop a strong relationship with a patient, we are committing ourselves for the duration of that patient's treatment in hospital. Sudden withdrawal may be damaging, in that the patient's worst fears and insecurities may seem to be justified by the nurse's apparent abandonment. This highlights the importance of nurses engaging and disengaging at appropriate points within the relationship, and ensuring that the nurse-patient relationship is openly discussed. Being realistic about what the relationship can and will provide is important, as is being truthful about one's own emotional involvement in the relationship – that is, that despite its intensity, the relationship is professional, not personal.

The nurse's role as the 'voice of reason' is an important one and its primary feature will be assisting the patient to broaden her/his perspective of the disease and the process of recovery. For example, patients frequently become distressed as they approach a weight that has personal importance or significance. This may or may not be the 'ideal' weight as specified by the treatment team. More often than not, it will be a weight at which the patient has previously considered her/himself to be 'out of control' or 'too fat', and it is frequently represented in numerical terms by a new 'decade' of kilograms (for example, moving from 39 to 40kgs). The patient's anxiety about reaching this weight will often lead to massive internal conflict and ambivalence. She/he may begin to restrict intake in an attempt to avoid anticipated emotions which it is feared could be engulfing. The patient's point of focus narrows and all they can think about is the half kilogram that will push them into the weight bracket most feared.

The nurse as 'voice of reason' can help the patient over such a hurdle. Assisting the patient to approach weight gain from a different perspective, broadening their focus and re-orientating them towards success are all functions of this role. Using metaphors to help explain the patient's ambivalence is a tactic nurses can use with great success. In the weight example described above, a patient might be asked to consider how they felt before and after their last birthday. Once the birthday was over, did they feel like a different person? Did they wake up looking older, or seeing the world differently? Did their body feel different? Patients are often surprised to discover that re-focussing and broadening their perspective, looking at their situation more objectively, and using the nurse as a sounding board to determine what is 'reasonable', will help to conquer fears and achieve success.

Setting limits and maintaining personal and professional boundaries

Fundamental to all professional Codes of Ethics is the distinction between professional and personal relationships. Once trust is established, nurses may feel deeply committed to the relationship they have worked so hard to develop. If one considers all the facets of the relationship - friendliness, trust, familiarity, empathy, responsiveness, caring, positive regard - it is easy to see why it could be misconstrued as a friendship, or why one or other of the parties may become confused about the purpose of the relationship. Neither the nurse nor the patient is immune. The nurse, particularly if a novice, may become over-involved with the patient or take personal affront at perceived failures or flouting of limits. In this situation it will then be more likely that the nurse experiences problems with countertransference. The patient may become dependent on the nurse, or feel burdened by the confusing messages received and transference problems may evolve.

For this reason, it is important that the nurse's roles and responsibilities are clearly defined with the patient, at the start of the relationship. Establishing and maintaining firm boundaries gives the patient and the nurse a directional focus. If this is not done it becomes difficult for the nurse to set effective limits - an essential feature supporting the structure of the program. A good induction process followed by clinical supervision, peer support, education and a consistent approach by all staff members will help to avoid such problems arising.

Taking on the role of multi-disciplinary treatment team coordinator

This comment by Doheny, Cook and Stopper (1992) has relevance to the current experience of nurses specialising in eating disorders:

> *Nurses are just beginning to expand their positions, assert themselves in terms of their knowledge and skill levels, and become aware of all they have to offer in addressing health care needs. The contemporary nurse is a forward-thinking decision maker who is an initiator of change* (p. 91).

Management of the care of patients with eating disorders must be a multi-disciplinary effort and role definition may be one of the most important functions involved in the smooth running of the multi-disciplinary team. The nurse's role includes implementing team management plans and developing nursing management plans where necessary. Nurses provide the background information required to evaluate the patient's progress, by monitoring dietary intake and level of activity. The nurse liaises with the family, the legal guardian or the mental health tribunal and supervises the consistent running of the program. He/she supports and counsels the patient through the difficulties experienced each day and conducts therapeutic groups in tandem with individual programs. Nurses also monitor the patient's physical condition and need to be aware of changes in physical observations, potential for cardiac complications, changes or alteration in cognitive presentation, and risk factors for, and the development of, refeeding syndrome.

It is the nurses who spend the most time with patients and a program has greater potential for success when a nurse is designated the role of team coordinator. If other members of the treatment team defer to the nurse with regard to day-to-day management of the program there are fewer problems with 'splitting' between disciplines. When patients understand that the other members of the treatment team consider that the nurse's role in their treatment plan is vital, the position of the nurse as coordinator is validated and their decisions or suggestions more readily accepted by the patient.

Clinical supervision, administrative support and education for other staff

In order to remain professional, maintain clear boundaries and examine one's personal feelings and emotional responses to the patient's eating disordered behaviour, clinical supervision and peer support are essential. In particular, nurses should use self-reflection to examine the features of the person's disease that engender a counter transference response.

Essential to confronting countertransference issues is the need to remember several key points about the process of hospitalisation for a patient with an eating disorder. First, that patients who come to hospital to participate in a refeeding program usually come under duress and feel completely physically and emotionally exposed. Second, they will fear being forced to give up the intricate rituals and mechanisms they have developed in response to their feelings of inadequacy. Third, they will be anxious about discussing their personal thoughts and feelings, angry that they have been forced into this course of action and initially determined in their efforts either to avoid complying with treatment or to minimise weight gain. Discussing countertransference issues in a clinical supervision setting will assist the nurse to maintain focus, enthusiasm and perspective. It will also assist the nurse to maintain the therapeutic alliance.

All health professionals involved in managing eating disorder patients must also consider issues of power and control. If not appropriately examined, these issues can affect the nurse patient relationship and impede the patient's progress. Developing a 'cooperative working alliance' establishes the relationship as being one in which power struggles do not occur. It must be understood that resistance to change is, in part, due to the patient's perception that, protected by the eating disorder she/he is 'in control', and that relinquishing dieting and purging behaviours equates to being 'out of control'. It is damaging for the nurse's own control issues to become a third unhelpful 'control' feature in this already unhealthy dyad (Sallas, 1985).

Winn (1994) cited in Lindsay (1997) suggests that experiential workshops assist in developing nurses' awareness of their own attitudes towards weight, shape, body image and food, and that developing such personal insight is *particularly crucial in view of the…anorexic patient's sensitivity to external influences. For if the nurse secretly admires the anorexic patient, or envies her rigid control over body weight, her interactions will not be therapeutic* (Orbach 1993 in Lindsay 1997, p. 130). Further, Muller and Poggenpoel (1996) note that *depending on whether reactions are appropriate to the situation or are based on their subjective reactions, nurses may either facilitate or stall the therapeutic process* (p. 143).

Nursing patients with eating disorders is a time consuming process. Provision of adequate staffing levels will help avoid burnout, reduce the potential for problems with countertransference and help to maintain positive staff attitudes. Managers also need to be aware of the energy nurses invest in these patients, give positive feedback for their efforts and ensure they have the opportunity to attend conferences, conduct nursing research, and seek continuing education. Where managers support the efforts of nurses on the eating disorder team, other staff members may be encouraged to participate.

While it is unlikely that all nurses on a unit will be eager to specialise in eating disorders, all will need to be aware of the fundamental aspects of the program. This is essential to maintain consistency with regard to general program issues – such as regular periods of bed rest, leave from the unit, and meal routines – and will ensure that nurses are not unnecessarily stringent. In fact, stringent behavioural programs have not been used in NSW for some years, and research shows little difference in outcome between these and the more lenient programs used today (Touyz et al. 1994).

Maintaining documentation and ensuring effective communication

Communication and consistency between eating disorders team members and other staff are vital to success. Management plans should be clearly documented to avoid problems arising when the primary nurse is off duty, as confusion or lack of consistency cause high anxiety for the patient. It can also undermine the efficacy and structure of the program if the patient comes to realise that there are "holes in the floor plan", and that they can get away with not attending to various aspects of their program when particular nurses are on duty. Having said that, it is important to remember that consistency does not mean rigidity. A firm, but flexible and reasonable approach will improve the likelihood that the patient develops a sense of trust in the primary nurse and the nursing team.

Eating disorder nurses will benefit from informal but regular meetings – updating each other on interactions with specific patients, discussing aspects of programs which are causing difficulty, defusing and giving each other moral support, and handing over before holidays and days off. Time should be allocated for these group discussions away from handover time and unit staff meetings.

Concluding discussion

This paper has highlighted the complex and pivotal role of the nurse in the management of eating disorder patients. There are several key issues which need to be reiterated, and commented on.

Ideally, all undergraduate and postgraduate mental health nursing programs should include more in-depth education about the eating disorders. Generally, nursing courses briefly overview the DSMIV criteria for these disorders but do not go much further. This means that nurses in the field are largely self-taught. While this is an indicator of those nurses' dedication, it also means that nurses are practicing from different knowledge bases, making it difficult to develop a common platform of understanding upon which a strong foundation of clinical management can be laid.

Opportunities for continuing education are essential for nurses practicing in this field. Strategies for enabling nurses to participate in all types of education – from sitting in the library and reading journal articles, to attending workshops, conferences or courses need to be explored. This should include some support in funding and time from workplaces.

Implementing group and individual clinical supervision and time for informal staff meetings would promote consistency within programs, and help avoid the potential for the development of countertransference issues, emotional over-or-under-involvement, and/or burnout. The provision of adequate numbers of nursing staff, is an important issue.

As with any multi-disciplinary team, roles must be well defined, and a collegial atmosphere in which members support each other, and respect each other's contributions and responsibilities, needs to be developed. Networking should also be encouraged, so that nurses form links with nurses from other units and other countries. This would assist with the continuing development of nursing skills and innovation, with cross fertilisation of ideas, and reduction of the likelihood of professional isolation becoming a problem.

Developing some centres of excellence, rather than only small isolated satellite units, would provide a centralised pool of skilled nurses, improve consistency, and encourage research and the continuing development of best practice models. Ideally, such centres would be linked with community health centres where appropriately skilled community nurses could take on some of the responsibility for identifying patients at risk, engaging early intervention strategies, managing the care of chronic sufferers, providing follow-up for those discharged from hospital, and implementing prevention programs where appropriate.

Currently, community nurses are under-utilised (if used at all) in the management of eating disorders. The community nurse's role could extend to education for school counsellors and teachers; liaison with parent groups; providing support for general practitioners; becoming involved with consumer support networks; and establishing out-patient clinics at women's health centres and community centres. Also important would be visits to gyms, sporting associations and universities and the provision of education to people in positions to influence health behaviours. The public health possibilities are vast, and the potential for nurses to have an impact on risk reduction and education, significant.

A more comprehensive nursing education program would assist in the implementation of this type of service plan by providing nurses with the skills required. It would also help in the recruitment of nurses with interest and aptitude in this field. Service plans would need to include appropriate levels of funding to support these expanded roles.

Consideration should be given to the future role of mental health nurse practitioners in the multi-disciplinary treatment team. It has been established that the team approach is essential and that nurses perform a vital role in the treatment team. They are able to manage the physiological and psychological aspects of these disorders, and are well placed to make a profound impact on the recovery of hospitalised patients. Nurses must be allowed to contribute to decisions about policy matters and service delivery issues in relation to providing services for people with eating disorders, and encouraged to participate in research, education, and clinical skills development. It is also possible that appropriately skilled community mental health nurses could take on the role of coordinating treatment for eating disorder patients, particularly in areas where other health professionals are not suitably trained.

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Chapter 14 – Dietetics and Nutrition

Hazel Williams and Maureen O'Connor

Since the mid 1970s, when the incidence of eating disorders began to increase in Australia, dietitians have been actively involved in their treatment. The authors of this chapter were both pioneers in the development of nutritional management guidelines for eating disorders, and have remained experts in this field. We have a unique perspective on the changing presentation and treatment of eating disordered individuals over this time span, and the changing influences on dieting behaviour, both in these patients and in society generally.

The dietitian's role in treatment

Based on research and experience it is evident that many of the physical and psychological problems associated with eating disorders are a consequence of the state of malnutrition; either starvation in anorexia nervosa, or a chaotic eating pattern with binge eating and purging in bulimia (Beumont, O'Connor, Williams and Touyz, 1987). On re-establishment of a regular, healthy eating pattern and normal body weight, physical health will generally return to normal, and many of the psychological problems will be relieved. Restoration of normal eating and a healthy body weight are therefore of primary importance for recovery. In order to achieve these outcomes, issues relating to eating patterns, weight-controlling behaviours, nutritional needs for healthy weight, body image, and food beliefs must be addressed during treatment. The dietitian is the most appropriate professional to address these issues (American Dietetic Association, 1994).

Due to their varied clinical and community work, dietitians are also in a position to recognise the signs of an incipient or fully developed eating disorder in 'at risk' populations which includes athletes, young women and overweight people. Ideally, specialist dietitians treat eating disordered patients as part of a multidisciplinary team of therapists, including a psychiatrist, psychologist, general practitioner and family therapist. However, the reality is that eating disordered patients are most commonly referred to dietitians in their general outpatient clinics or private practice, where there is minimal support from other specialists in this field. This is particularly evident in rural areas. The dietitian can be the first point of referral because eating disorders are considered as primarily 'food and eating problems', and because there may be a reduced perception of threat or stigma attached to seeing a dietitian rather than a psychiatrist. This places a tremendous responsibility on dietitians, who need to have considerable specialist knowledge if they are to provide effective patient care. They also need to know their own boundaries and limitations for providing treatment and when it is appropriate to refer patients for more specialist medical and psychological care.

Nutritional management of eating disorders

Restrictive dieting is considered the most commonly recognised risk factor for any eating disorder, and nutritional rehabilitation is seen as the essential first step in treatment (Butow, Touyz, Freeman and Beumont, 1988; Patton, Johnson-Sabine, Wood, Mann and Wakeling, 1990; Kendler, Maclean, Neale, Kessler, Heath and Eaves, 1991). In anorexia nervosa it is important to negate the effects of starvation and hence improve cognitive functioning to enable engagement in psychotherapy. In bulimia nervosa nutritional counselling helps to control the chaotic eating behaviour and enables patients to focus on the underlying psychological issues (Beumont, Beumont, Touyz and Williams, 1997).

The primary aim in dietary treatment is to help patients refrain from restrictive dieting and therefore break the diet/binge/purge cycle in bulimia, and to restore normal healthy weight in anorexia. Patients need education, advice and support to help them establish a normal eating pattern and to accept and maintain a healthy body weight. They may no longer recognise or trust their hunger and satiety cues and have many fears and misconceptions related to food and weight control which need identification and correction. Dietetic input is invaluable in promoting an accurate knowledge base and, as dietitians are considered experts in nutrition, patients are often more trusting of their advice. Dietary treatment for these patients incorporates three main components: Nutritional assessment, education, and facilitation of behaviour changes.

Nutritional assessment

Dietitians take a comprehensive nutritional assessment of patients at the first consultation. This assesses past and current eating, dieting and other weight losing behaviours, and life events that might have influenced attitudes to weight, eating and body image. This may include the attitudes and eating patterns of family and friends; comments that significant people have made to them about their appearance; or advice that a sports coach or ballet teacher might have given them about their weight. Younger patients (under 18 years), usually have a parent or other appropriate family member included during the consultation to provide the family's perspective on the illness and its impact on normal family life.

The dietitian uses the patient's relevant medical history and recent blood test results to provide essential information about contributing or concurrent illnesses; the patient's state of hydration; blood sugar level; phosphate, electrolytes and iron stores. These measures effect the specifics of dietary advice, as well as indicating whether the patient should be immediately referred to other specialists, or for admission to an inpatient unit (if either of these options are available). If the patient has not been referred by a General Practitioner, then the dietitian should insist that they make an appointment for a general medical check up and blood tests before the next appointment.

Anthropometric measures are usually taken at the first interview to ascertain the patient's body mass index to help make a diagnosis and provide guidelines for the patient's healthy weight range. Additional information about the patient's activity level can help to detect excessive or obsessional exercise behaviours. Due to a paucity of exercise therapists specialising in eating disorders, the dietitian is often required to provide guidelines for normal activity levels, as well as normal eating. During the process of making the nutritional assessment and in the early stages of treatment, it is very important that a trusting and open relationship develops between the patient and dietitian. This assists the patient to begin to share their fears and abnormal behaviours and promotes trust in the dietitian's guidelines for change.

Nutrition Education

Education is integrated throughout treatment as different issues arise. One to one sessions are the most common approach but group discussions can also be very effective, with patients at different stages of recovery sharing their thoughts and strategies for change. Important topics for discussion include nutritional needs and how these change during the recovery process; metabolism and weight control; the physical and psychological consequences of starvation and chaotic eating; and the dangers and ineffectiveness of purging. The patient's emotional relationship with food should be explored and food fears identified and discussed. Patients are encouraged to start thinking about how they used to eat; what others eat and what normal eating really means; rather than some idealised view of 'the perfect diet'. Guidelines for beginning to increase food intake or to establish a regular meal pattern in the case of bulimic patients would usually be provided by the dietitian. A healthy, balanced approach to eating should be emphasised, and the regular use of low fat and 'diet' foods discouraged. Diet food products are counterproductive for weight gain in anorexic patients, and keep bulimic patients locked into the belief that they have to diet. It can be a wonderful revelation for them to discover that they can maintain normal weight by eating normal, non-diet foods.

Appropriate family members are often included as part of the education sessions to help them to better understand and support the eating disordered family member. These patients have often totally withdrawn from family and social eating, although it is not uncommon for anorexic patients to determine what the whole family should eat, and even to cook all family meals. The dietitian can help the family to formulate healthy, appropriate guidelines for decision making about family meals, and how the eating disordered family member can best be supported. There is evidence that such psycho-educational treatment can improve eating behaviour especially if symptoms are not severe, illness is of a short duration and there are no personality disorders present (Fahy and Russell, 1993).

More severely ill patients need regular psychological and medical support, but this may not become evident until the patient is eating more normally. Once their usual coping strategies of dieting and/or binge eating and vomiting are removed, they become more aware of underlying issues and may become more emotionally disturbed. It is not recommended that the dietitian try to treat such patients alone and, if the patient is not undergoing psychological counselling, is best advised to undertake only the education phase for patient management. This would also be appropriate if the dietitian has little experience of working with eating disordered patients (American Dietetics Association, 1994).

Facilitating Change

If the patient is concurrently receiving psychological counselling and medical care, and the dietitian has the required experience and training, they may undertake the more intensive treatment phase. This focuses more on changes to the patient's eating behaviour and attitudes to food (American Dietetics Association, 1994). The therapeutic alliance between the dietitian and psychologist enables the patient, and therapists, to separate the food and weight-related behaviours from emotional issues. The GP and dietitian can also work together to help the patient understand the connection between the amount and variety of food that they eat, and their state of health and energy.

The aims of nutritional counselling in this phase of treatment are to help the patient to stop dieting, to cease non-dietary weight losing behaviours and to establish a regular meal pattern. Further, the patient is encouraged to include a variety of foods; relearn hunger and satiety cues; help overcome guilt associated with eating high energy 'fattening' foods, and to encourage spontaneous and flexible eating behaviour. Additional aims are for the patient to accept a healthy weight, develop a balanced attitude to food, and most importantly, to enjoy eating.

Realistic and mutual goals need to be developed and guidelines provided for modifying eating behaviour. Anorexic patients require gradual increments in the amount and variety of foods eaten to achieve steady weight gain at the rate of approximately 0.5kg to 1.0kg per week. Bulimic patients require guidelines for modifying eating behaviour through regular meals and snacks, and adequate energy intake to maintain a healthy weight. Patients are usually asked to self-monitor their food intake and mood, and to indicate particularly challenging eating occasions, or when binges occur and their possible triggers. Subsequent nutrition counselling sessions with bulimic patients will generally involve a review of self monitoring and highlighting any improvements. The dietitian encourages and checks progress, examines triggers for binges and suggests strategies to avoid bingeing in the future. Often there may be complex issues raised beyond those of eating and weight. For example the bulimic patient may discover that bingeing always follows an argument or feeling stressed at work. Common contributing factors may be poor self-esteem, relationship difficulties, low mood, and fear of losing control. Such issues may be identified during nutritional counselling sessions and dealt with in depth during psychotherapy. The patient's often irrational and negative beliefs about eating, weight and shape must also be addressed (Russell, 1991).

In subsequent sessions with anorexic patients, the patient's weight and recent food intake, both quantity and variety would be reviewed, and appropriate goals would be set for the continued progress towards a realistic and healthy minimum weight target. There is often disagreement about the minimum healthy weight as the patient may prefer to remain somewhat underweight. The dietitian needs to explain the reasons for achieving a normal weight incorporating the social enjoyment of eating, as well as attaining nutritional requirements and health. If underweight, the body has to continually diet to remain so. The parents of non-adult patients are consulted about many aspects of treatment and their support for treatment decisions is invaluable for a successful outcome, whereas their criticism can totally undermine treatment (Griffiths, Beaumont, Beumont, Touyz, Williams and Lowenger, 1995).

Another important issue in the weight-gaining phase of treatment is the type of food recommended for the patient who may have reduced their food choices to a very few, low energy, fat-free and very often protein-free foods (many anorexic patients mistakenly equate protein with fat). Patients may assert that they will eat any amount of their 'safe' foods but could not possibly eat foods they perceive to be 'fattening'. Sound nutrition education combined with encouragement from the dietitian is often enough, especially if the patient is also receiving psychotherapy. However, for patients who cannot make adequate changes a day patient or inpatient program in a specialist hospital unit may be required. High-energy liquid supplements may be a useful addition to the diet, if used prudently, when patients are struggling to eat sufficient quantities of food. Patients can, however, become too reliant on liquid meal substitutes to the detriment of adjusting to normal food. It is also very important that anorexic patients experience the large amounts of 'real' food that are necessary for sustained weight gain, and normal weight maintenance.

Nasogastric tube feeds are sometimes used for anorexic patients but dietitians would recommend that they be used very cautiously. There are physical risks to the patient if the tube is not inserted properly or if it becomes dislodged, which is highly likely when patients have one inserted against their will or try to pull it out. Nasogastric feeds can also delay the patient's adjustment to eating food and meals again and could be disastrous for future weight maintenance. Unfortunately patients may find a way to hinder treatment if they are antagonistic towards tube feeds by pulling the tube out, adjusting the controls, or decanting the tube feed into other containers when unobserved. Nasogastric feeds are only recommended for use in the most seriously ill patients, when other methods of feeding have been attempted, and preferably with the agreement of the patient.

The dietitian needs to constantly challenge the anorexic and bulimic patient's beliefs and attitudes to foods and their often very rigid dietary rules. These patients also need to be given permission (from a nutrition expert) to eat cake, chocolate, chips and other energy-dense snack foods, appropriately, and as part of a normal healthy eating pattern. Some dietitians find this aspect of treatment very challenging. In their training they have been taught the negative consequences of eating a high saturated fat diet, and are more used to dealing with overweight, diabetic or hyperlipidaemic patients. They can lose sight of the fact that normal healthy eating can easily include (and usually does for most of the population) moderate amounts of energy-dense foods. If a nutrition expert condones the avoidance of these foods, this will only act to reinforce the patient's belief that they are 'fattening' and 'bad'. This may contribute to further guilt and exacerbation of the disorder. Dietitians need to consider that patients often view food only from the perspective of weight, not taste or health, appetite or fun and need to feel comfortable encouraging eating disordered patients to eat a truly wide range of all types of food. Further information regarding nutritional management of eating disorders can be located in the resources of the American Dietetic Association, 1994; Beumont et al. 1987; O'Connor et al. 1989; Williams and Beumont, 1990.

Current training of dietitians

Touyz and Beumont (1999) suggest that anorexia nervosa is the third most common chronic illness among teenage girls in Australia, after obesity and asthma, and is five times as common as Type 1 diabetes. However, the incidence of bulimia has been reported as at least twice that of anorexia nervosa (Russell, 1997). Dietitians are an integral part of specialist treatment teams and they are often the first point of referral for these patients in general outpatient clinics. Dietitians also need to be alert for eating disorders, especially amongst those presenting at weight loss or diabetic clinics, or for sports nutrition advice. To effectively manage the care of eating disordered patients, therapists, including dietitians, must be experienced in treating these patients and have a good understanding of the psychopathology of this population (Wifley and Grilo, 1994; Beumont et al. 1987).

Ideally, eating disorders should be a major topic in the basic university preparation of nutrition and dietetics students. There are approximately four to six hours of lectures and tutorial time dedicated to eating disorders in four year undergraduate courses or two year postgraduate courses. It is also unusual for student dietitians to have a practical placement with eating disordered patients. The dietetic courses have an extensive knowledge base to address, but the amount of time spent on eating disorders seems minimal proportional to the time spent on other clinical conditions with smaller incidences in the population. In recognition of this, a small group of dietitians who specialise in the treatment of eating disorders have provided workshops and seminars. Although they have always been extremely well attended, their organisation is costly in time and money and consequently, their frequency has decreased in recent years.

It is strongly recommended that the basic dietetic course increases its eating disorders component and incorporates more practical placements with eating disorder treatment clinics. New graduates should have the knowledge and ability to carry out the assessment and education phase of treatment, and be taught how to routinely screen for eating disorders amongst at risk populations. This can be done by asking questions such as 'What weight would you like to be?' 'Are you often preoccupied with thoughts of food and weight?' 'Do you ever eat in secret?' ' Do you sometimes feel out of control with your eating?' It is also recommended that an annual post-graduate course in nutritional management of eating disorders be made available at some of the universities currently providing dietetic courses. These need be only short programs and could provide some supervision for clinical practice. These strategies could assist the provision of increased numbers of well-qualified specialist dietitians, in rural as well as metropolitan areas.

The availability of specialist dietitians

Eating disordered patients differ from those usually seen in clinical dietetic practice in several ways. They may not be open about, or even aware of, the full extent of their emotional relationship with food, or their weight controlling behaviours. In addition, they may need more than just education about food and weight-related behaviours. Dietitians need to be very aware of the psychological aspects of these problems and ensure that the client is also receiving psychological counselling. Motivation to attain a 'normal' eating pattern may be limited and it may take many sessions to build up a trusting therapeutic relationship. It is important that the dietitian does not expect rapid progress and is prepared to assist these patients for the duration of what is often a protracted illness. These patients require considerable intensive therapy time, as well as expertise.

Unfortunately, there are very limited numbers of dietitians in the public health system with such expertise, and they are heavily booked with outpatients, and may have inadequate support from psychologists. This can result in long waiting lists for new patients, during which time they may become progressively worse, or at best, remain unchanged (Fahy and Russell, 1993). Dietitians can also become over-burdened and at risk of burn out. There are more inpatient and outpatient services available in the private health system, but outpatient dietetic consultations are only partially refunded by the private health funds. This can be extremely costly for patients, whether they are privately insured or not, due to the protracted nature of eating disorders and the need to receive nutritional counselling on a regular basis.

In this respect, our recommendations are firstly to improve the availability of specialist dietitians in the public system. Studies have shown that early treatment of eating disorders improves the prognosis (Morgan, Purgold and Welbourne, 1983; Keel, Mitchell, Miller, Davis and Crow, 1999) and it makes therapeutic and financial sense to provide more training and more specialist outpatient time for these patients. Secondly, health fund rebates for specialist dietitians in private practice need to be increased.

Co-ordination of care

At present, the care of eating disordered individuals is often fragmented (Zbornik, 1996), and there is poor communication about available treatment options. Sufferers and their families become frustrated by not knowing where to get help when they finally have the courage and motivation to seek it. Those in primary care, such as GPs, dietitians, school counsellors, and community health centre workers, are often unaware of the specialist services available (Zbornik, 1996). A coordinated, multidisciplinary team approach is currently the most effective method for treating patients with eating disorders and significantly better outcomes are achieved if patients are treated in a specialist unit. The team should consist of a clinical psychologist, specialist dietitian, and GP under the supervision of a specialist psychiatrist (American Psychiatric Association Guidelines, 1993). However, there is limited capacity to provide such a team approach outside public teaching hospitals.

Financial and geographical obstacles will always inhibit the availability of specialist treatment centres throughout rural and metropolitan Australia. Other solutions need to be found as delays in treatment, length of waiting lists and distances eating disordered individuals must often travel for care are unacceptable. In NSW, the Eating Disorder GP Shared Care Program, described in Chapter 15 (Smith), is beginning to address this problem.

Social and cultural issues

There are a multitude of social and cultural issues that influence our body image and eating behaviours, and no doubt contribute to the development of eating disorders in vulnerable individuals. Many of these are discussed in depth elsewhere in this publication. There are two areas that regularly feature in the profiles of our eating disordered patients about which we, as dietitians, are particularly concerned.

Society's obsession with fat-avoidance

In modern times, eating disordered patients reflect the dieting and exercise trends that prevail in society generally, but often to a more extreme extent. When popular weight loss figures of the 1960s and early 1970s recommended that society needed to avoid starchy foods, anorexic patients tended to totally avoid bread and potatoes, but would still eat meat and drink whole milk. In the mid 1970s, research into heart disease identified dietary fats, and specifically saturated animal fats, as major contributors to the high incidence of heart disease. It became a false belief that fat was 'bad' and subsequently a variety of fat-free and reduced fat food products were made available. Fat is also an energy-dense food and similar to the material on our bodies females were beginning to hate, so the term 'bad' became synonymous with 'fattening'. Weight reduction programs began to advise people that the major concern was to minimise fat intake and that starchy foods were now 'good'. The eating disordered population became expert at avoiding dietary fat and we often find that fat is always the most feared food among these patients. They usually erroneously think that dietary fat automatically becomes fat on the body.

As a means of weight reduction, young women have responded much more vehemently to the basic cholesterol-lowering message primarily intended for men. Foods that are perceived as containing any fat, such as milk products and meat, are avoided as 'bad' and 'fattening'. Females have special needs for dietary iron and calcium but the national dietary survey of 1995 indicated that 60% – 70% of females have inadequate iron and calcium intakes as a result of avoiding these foods (ABS, 1998). Men and women who have grown up with this anti-fat and 'thin is beautiful' ideal pass their beliefs and eating preferences on to their children, teachers to pupils, food companies to the public, and dietitians to patients. Among the potential eating disorder sufferers who tend to take things to extremes, 'eat less fat' means the less fat consumed the better and thinner you will be. While the incidence of heart disease has certainly reduced over the last two decades, there is no doubt that it has been assisted by the replacement of saturated fats with monounsaturated and polyunsaturated fats in our diet. It may be that men's cardiovascular health has improved to the detriment of women's dietary health.

We are very concerned about the misinterpretation, simplification and exaggeration of the health messages about dietary fat. We are not suggesting that the Australian population should revert to eating as much saturated fat as they did in the pre-1970s, but fat remains an essential component of our diet. This is rarely emphasised and the recommendation to have a low fat intake should be replaced by a moderate fat intake. There should also be positive encouragement to eat the health-promoting oils and fats, rather than perpetuating negative messages about all fat. The dietetic profession has also contributed to the anti-fat propaganda, and should take some responsibility for redressing the balance.

Parents, teachers and coaches

O'Dea, Abraham and Heard (1996) suggest that an unbalanced attitude to food and body image starts at an early age and one needs to question where these unbalanced attitudes come from. Influential adults have a profound effect on our beliefs and behaviours as we are growing up, as we watch and copy what they do, and listen to what they say about us. Our level of self-esteem is built upon praise or criticism, and the encouragement or discouragement that we receive. Recurrent issues referred to by anorexic and bulimic patients as contributing to their attitude to body shape and weight, and reasons for beginning to diet, relate to what significant people have said or done. Examples include statements such as: 'Dad used to call me thunder thighs'; 'Mum always said that men can eat red meat but women can only eat chicken'; 'My ballet teacher told me I looked too big'; 'My coach told me that I would run faster if I lost weight'; 'We were all weighed at school and our weights put on the board to learn about graphs. I felt awful because I was one of the heaviest'. None of these people deliberately intended their words to be a contributing factor in the development of an eating disorder. Most of us do not appreciate the profound effects our behaviours and comments can have on our children or students (Wertheim, Paxton, Schutz and Muir, 1997; McCabe and Ricciardelli, 1999). There are many opportunities available to promote positive self-esteem, body image and eating habits, such as in ante-natal classes, teacher-training courses, coaching courses, magazine articles, school lessons, talk-back radio and TV health and lifestyle programs.

Summary

Dietitians have been making a valuable contribution to the treatment of eating disorders for over 20 years. Ideally, they work in multidisciplinary specialist teams, but in reality, most work alone. Dietitians need specialist training to both confidently and effectively treat these patients. Because treatment resources are generally fragmented and difficult to locate, a national register of therapists and treatment centres, including a web site are recommended. Dietitians who treat eating disorders are also concerned about the extreme anti-fat phobia in society, and the lack of awareness and care taken by significant adults in children's lives to promote positive self-esteem and attitudes towards eating and weight.

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Chapter 15 – Treatment Issues in General Practice

Aline Smith

Many patients with eating disorders remain unidentified until the harmful behaviours become deeply entrenched. Existing evidence shows that treatment is easier and more effective in the earlier stages of these illnesses (Spielman, 1996) and that the prognosis for patients with eating disorders is better the shorter the duration of illness. The challenge for General Practitioners (GPs) is to identify early signs of an eating disorder and intervene appropriately to encourage these patients to seek treatment. A list of early warning signs was developed by the Central Sydney Division of General Practice Eating Disorders Project in 1999 and is included as Appendix 1.

After asthma and obesity, eating disorders is the third most common disorder in adolescent girls (Wilhelm and Clarke, 1998). Consequently, GPs need to be alert to signs of an eating disorder. Fairburn (1995) argues that some people go to their doctor planning to divulge the problem but lose their nerve at the last moment. One of the obstacles to seeking help is 'difficulty telling doctors' (Fairburn, 1995). Therefore, an empathic doctor who can ask the right questions is in a good position to encourage patients to disclose their 'secret' illness and thus offer help as early as possible. The GP has a number of opportunities for a prompt diagnosis. Ogg, Millar, Pusztai & Thom (1997) found that, in the five years prior to diagnosis, people with eating disorders consulted GPs more frequently than other patients of a similar age or background.

It is useful to maintain a high index of suspicion when considering the possibility of a diagnosis in patients who present with a variety of symptoms. Gastrointestinal problems such as complaints of constipation, feelings of bloatedness and vague abdominal pains may be a suspicious presentation. Menstrual irregularities, vegetarianism and a keenness to exercise may also be symptoms. People who complain about food allergies or intolerances to a range of sugars, fat and carbohydrate food, or have obsessive concerns about diets and dietary matters may need to be questioned further about their eating habits and other obsessional traits. Further questions regarding weight issues and eating habits may need to be explored, particularly normal or underweight women who are keen on healthy, non-fat diets.

A high index of suspicion should also be maintained when talking to young patients about drug taking behaviours. For example, smoking is often used by adolescent girls to stop hunger pangs and reduce appetite. Further questioning about why the person smokes may therefore be helpful. The use of appetite suppressants, stimulants, laxatives and diuretics may also be a clue to the need for further questioning about weight and body image issues. Some patients may use alcohol in binges so it is important to ask about the way the alcohol is being consumed as well as the amount of alcohol consumed per day. Other drug taking behaviours including intravenous drug use, marijuana and recreational drugs like 'ecstasy' need to be specifically addressed as possible clues to body image issues. Similarly, patients who present with mood changes such as depression, anxiety or low self-esteem may need to be asked about their eating habits and weight concerns.

An eating disorder may be present when a patient seeks help regarding a major change or traumatic life event. General practitioners need to be vigilant in identifying these at-risk groups and intervene appropriately at the level that is required. It may mean seeing the patient more regularly to offer supportive counselling, giving the patient basic facts about how poor nutrition affects mood changes or arranging referral. Wilhelm and Clarke (1998) believe that GPs play an important part in the initiation of treatment before disordered eating patterns become entrenched. After the initial diagnosis, the next challenge is to persuade the patient to accept a need for treatment and to obtain effective help for these patients.

Case study one

Mandy was a young girl who presented for a laxative prescription as her usual doctor was unavailable. She had been having problems with abdominal pain, was constipated and requested a stronger laxative. She had tried most over-the-counter laxatives but they were not effective. She had just started a new job, was not eating regularly and was skipping meals. On further questioning, Mandy admitted she had lost a bit of weight since starting her new job. Apart from skipping meals, she had begun to restrict her calorie intake by becoming a vegetarian and stopping dairy foods. She thought she had been suffering from food allergies. Other problems Mandy experienced were tiredness, moodiness and erratic menstrual periods.

On physical examination, Mandy looked thin and pale. Her height and weight was measured and this was found to be within the normal range. She was not clinically constipated on physical examination.

After telling Mandy that her constipation was probably due to a poor diet, she admitted to me that she had a problem with stress, controlling her weight and had difficulties managing her diet. She agreed to return to her usual GP for blood tests *and agreed to see a dietitian skilled in eating disorder management. She did not leave my practice with a laxative prescription but instead left with a structured treatment plan.*

Coordinating care of patients

Unlike specialist services and hospital programs, patients have relatively easy access to GPs. Because of this, the GP has an opportunity to understand the particular needs of patients and is well placed to coordinate the care of their patients as necessary. This role is akin to the GPs' role in managing any chronic illness such as dementia, diabetes, enduring mental illness, or chronic pain. By listening to their patients effectively, GPs are able to diagnose, assess severity of the illness, and organise relevant investigations.

The management plan usually involves a multidisciplinary approach. However, it needs to be emphasised that the first few appointments with an eating disordered patient need to focus on establishing rapport. According to Wilhelm and Clarke (1998), forging a therapeutic alliance with the patient is an important intervention. A positive self image and a coherent sense of self are essential elements to be developed in patients and this can best be achieved by establishing a working friendship between doctor and patient.

Depending on the severity and nature of the illness, referral could include medical specialists, dietitians, psychiatrists, psychologists, treatment clinics or hospital admission. The decision to refer or consult other specialist services rests on a variety of factors including availability of specialist services; the particular interests and skills of the general practitioner; family considerations; presence of comorbidity, or financial considerations. For example, after initial assessment, patients may need to be referred to a drug and alcohol service or sexual assault service. In younger patients, where there are significant family problems, referral to a family therapist may be warranted. Patients may have limited access to therapy and treatment options and may face long waiting times for appointments if they are unable to afford treatment in the private health sector.

Case study two

Kim has bulimia nervosa. During her teenage years, she suffered from anorexia nervosa although in the past few years, she has had difficulties with binge eating, purging and some episodes of restrictive eating. She has been able to hold down a full time job in the past six months and had started seeing a young man in a new relationship. She wanted some help to deal with her eating disorder, frustrated that she is still being controlled by food. However, when she went to her own doctor to discuss her needs and her frustrations around her lack of control over food and her eating behaviour, her doctor told her that she did not have a serious problem, and that all she had to do was to eat properly. When she presented to me for consultation, she was obviously very upset by what she had been told. She felt that she had not been listened to and had been dismissed as a weak and silly person. Her self-esteem had taken a nose-dive as she explained it had taken her some time to work up enough courage to tell her doctor her problems. Following regular counselling, Kim was referred to a dietitian skilled in eating disorder management and a psychologist skilled in cognitive-behavioural therapy. It was felt that Kim was at the stage when she reallly wanted to change her behaviours although she needed some specific strategies to facilitate this change. As Kim had been amenorrhoeic for more than 18 months, arrangements were made for her to have a bone mineral densitometry test. The results showed that she was osteopenic and a consultation with an endocrinologist was arranged for her.

After several interviews with Kim, she finally described her real fears. These were related to her being physically and emotionally abused by her parents from childhood. Even though she was in her early twenties, she was still living at home in a dysfunctional household, continually being subjected to abuse from her alcoholic father. Assistance was provided to organise Kim to have access to emergency accommodation and information about apprehended violence orders (AVOs).

It is important to know to whom and where to refer patients and a list of local resources is an invaluable tool. At times it can be frustrating and time consuming when trying to arrange appointments for patients in the public system. The referral system may be unwieldy and patients can be required to wait in excess of three months to gain an appointment.

Case study three

Toni, a college student was accompanied by her mother for treatment of what she suspected was an eating disorder. Toni had been concerned about weight issues two years earlier when she began taking the oral contraceptive pill for treatment of acne. She started to put on weight after starting the pill.

On presentation, Toni was clinically depressed. She reported depressed mood, insomnia, anxiety symptoms, low self-esteem and loss of concentration. She was crying daily and even though she did not have a clear plan for suicide, she had thought about ending it all. She was frustrated about her inability to control her eating and purging behaviours. She was angry with her father who himself suffers from a chronic mental disorder because she felt that because of his illness, she had been 'robbed of her youth' and 'normal childhood experiences'. Toni had been the person in the family who spent the most time with her father because he was housebound and her mother worked full time. Her two brothers had moved out of home.

Due to these circumstances, it was important that Toni received treatment quickly. Even though on physical examination she had no urgent problems and further investigations were negative, she needed help in a multidisciplinary setting as soon as possible. As she elected to be treated as a public patient, an appointment was made with the eating disorder clinic most accessible to her. While an appointment had been secured, it was later cancelled because the service found out that Toni lived 'out of the area'. She was referred to the next nearest hospital *for a booking. On phoning the hospital, the operator was unable to locate the appropriate service and after numerous phone calls, the adult mental health service intake psychologist spent more than 10 minutes finding out that indeed, she was out of area for their service as well. Eventually after speaking to several people, it was found that the eating disorder clinic that she was eligible to access was not taking any referrals because of staffing problems. Despite this, Toni managed to secure her appointment with the service contacted initially but only after further calls were made to explain the difficulties we had in getting through to the right service. Thanks to a persistent patient, mother and doctor, Toni is now undergoing appropriate treatment!*

When the appointment is finally made, the important factor is that the GP remains the crucial link in the chain of therapists and specialists. This ensures that the patient has a stable point of reference to which they can return during or after completing treatment or therapy with other specialists. General practitioners are also useful in providing the necessary encouragement and reinforcement of treatment and therapy initiated by the specialist services. Often patients will find it helpful to have a caring GP who takes the time to listen, explain and interpret as well as motivate them to change.

General practitioners themselves have to accept the chronic nature of eating disorders and realise that change is gradual and may be a very slow process. Consequently, it is important that GPs regularly review the patient's health and medical status. As motivation for engaging in treatment or therapy may wax and wane, GPs need to accept that this is similar to the course of any chronic illness and to leave-the-door-open for the patient to return at a later stage.

The Eating Disorder GP Shared Care Project

In 1997, the Central Sydney Division of General Practice, together with the Royal Prince Alfred Hospital Eating Disorders Outpatient Clinic, jointly developed an Eating Disorder Shared Care Project. This project enhanced the skills of GPs interested in treating patients with eating disorders and provided specialist back-up and referral resources.

The shared care aspect of the project involved the shared management of a patient who had been either referred by the GP to the specialists at the Eating Disorders Clinic or from the specialist service to the GP involved in the project. Any patients without a regular GP who contacted the Eating Disorders Clinic were referred to one of the participating GPs for them to determine if referral back to the Clinic for formal assessment or specific specialist back-up was necessary.

From the Clinic's perspective, the shared care GPs were a real resource for the specialists in that they were able to refer patients to GPs with the appropriate skills in treating patients with eating disorders. Monthly clinical conferences, combined with the presentation of relevant educational material provided a forum where GPs and the specialist service providers share information about the progress of patients in the shared care project. This approach enabled GPs to gain access to advice from specialists in a timely manner. Ideally, the service would be able to assume responsibility for the patient's care including admission if warranted.

The NSW state wide program

The NSW Eating Disorder GP Shared Care program (Marks, 2000) is a two year project funded by the NSW Health Department's Centre for Mental Health, and is coordinated by the University of Sydney's Department of Psychological Medicine. The program contains five components which may be taken separately by GPs wishing to increase their knowledge about the disorders, or as part of a 12 month program for those wanting to sub-specialise in eating disorders (and obtain a Diploma of Shared Care in Psychiatry (Eating Disorders) from the NSW Institute of Psychiatry).

The project aims to:

- Develop a comprehensive diploma level training and educational curriculum for GPs in the identification and management of eating disorders.
- Develop a network of GPs across NSW who sub-specialise in the case management of patients with these disorders.
- Improve links between GPs and specialist providers, by establishing a consultation-liaison style shared care service, in order to improve continuum of care across treatment modalities.
- Assist in the development of local area multi-disciplinary networks of health professionals interested in eating disorder patients and to provide GPs with more easily identifiable resources for referral.

The program has three core components: a weekend workshop, follow-up clinical conferences and follow-up education sessions. There is a choice of two electives: either attendance at an outpatient clinic or an in-patient case review. Two multi-disciplinary project teams have been established, each comprised of a GP, psychiatrist, mental health care nurse, dietitian, consumer and psychologist. Development of the curriculum is almost completed and the document includes some excellent contributions from eating disorder specialists in British Columbia, Germany, New Zealand and the USA. The response to the project has been favourable, with a majority of those interested registering to participate in the shared care diploma. Of the 39 Divisions of General Practice in NSW, 13 indicated an interest in hosting a weekend workshop, and between 30 and 40 GPs will attend each of the four workshops.

It is anticipated that the benefits of the project will include an increased awareness by GPs of those at risk; an increase in detection of clinical and subclinical dieting disorders, and a concurrent increase in the implementation of early intervention strategies. A desirable outcome would be an overall reduction in the number of patients requiring referral to specialist services and a decrease in the number of patients progressing to severe illness, or requiring in-patient treatment.

The problems highlighted at this early stage of the project include the time constraints of GPs; the lack of suitably trained non-GP health professionals (particularly in areas outside Sydney) with whom GPs could develop multidisciplinary management teams; remuneration issues where patients require long consultation sessions; and the need to use 'telemedicine' and electronic media as tools of education where these are not widely accessed by GPs. Project evaluation tools are currently being developed in the following five areas of interest: (a) development of an infrastructure to support a shared care endeavour (b) service to GPs (c) GP knowledge, skills and attitudes (d) GP service to consumers and consumer feedback, and (e) impact on the health of the community.

The success of this type of shared-care approach to treating patients is only possible if GPs and specialists have a good understanding of their respective roles and the services that each can provide. Open communication between GP and specialist services facilitates a coordinated approach to treating patients with an eating disorder. This is particularly important as part of the discharge planning process following patient discharge from treatment facilities or hospital programs.

Finally, as case manager, the GP's main tasks revolve around the initial assessment of patient needs, linking patients into appropriate services, maintaining communication links between all involved parties, monitoring and follow up to ensure progress towards the treatment goals.

Support for families and friends

The GP is not only involved in the lives of their patients but it is inevitable that at some stage they will become similarly involved with the patient's family and or friends. The families of a patient who has an eating disorder often are so traumatised by this experience that they may also need advice, information or in some cases referral for psychological assessment and treatment. It is helpful for them to know about community support groups and relevant government departments who offer a variety of resources to sufferers, their friends and families as well as students and interested professionals. Most states and territories in Australia now have one or more groups specifically for eating disorders.

It may be appropriate, and often very useful, to offer the family or at least the parents a few interviews especially if the adolescent patient is still living at home with the parents. These meetings can be useful for the clinician to gather further information about the condition and how it affects the rest of the family. It is also an opportunity to assess the family situation and the need for family therapy. Often, when there are no serious family problems, meetings with the family can help alleviate a sense of guilt or fear.

Case study four

This patient with an eating disorder did not directly seek a consultation. Her mother came to see me with concerns for her daughter whom she thought might have an eating disorder. Her daughter is in her twenties and no longer lives with the family. I initially saw both parents because they were so concerned for their daughter.

From what they described to me, a general assessment was possible of their daughter's eating problem, which was not severe, but certainly worth better assessment. I was able to give the parents some strategies to encourage their daughter to seek help, point them to local family support groups and give them relevant information about eating disorders. One of the main issues we addressed was the guilt that they both had about not addressing their daughter's problem earlier, and their incredible sadness and feelings of powerlessness to effectively help their daughter through the illness.

Most importantly, the contact with the parents was helpful because the parents themselves needed guidance and support. During the previous two years they had had to cope not only with the sudden change in their daughter's life, but with several challenging life stressors of their own including job loss. It was evident that the father was suffering from a major depression. He had noticed that he had become more withdrawn and anxious over the preceding months, and agreed to commence antidepressant therapy. I referred him to a psychiatrist.

The case studies illustrate three main points about the role of the general practitioner:

Firstly, GPs are the initial point of contact in many instances for early diagnosis and intervention. General practitioners need to have the awareness to pick up the early signs and symptoms of eating disorders and need to be vigilant in identifying groups at risk. Evidence exists that early detection and treatment of this illness can prevent chronic disability and poor outcome for patients with eating disorders. Secondly, GPs are well placed to coordinate the care of their patients as their needs are known to them. Finally the GP is involved in the lives of his or her patients, not only in supporting the sufferers but also their families and friends. Once rapport is established, the GP becomes a crucial link in the chain of therapists and specialists. It is not unusual for patients and their families to keep returning for ongoing help and follow-up assessments.

General practitioners have a special role as a stable reference point from which patients and their families can move. I find this an enormously rewarding role as a general practitioner and enjoy the positive aspect of seeing people change and gain better health in the long term. I think there is much hope in the future for people suffering with eating disorders. The evidence for this lies in the definite but slow change in community attitudes, better informed education, continuing research, better informed general practitioner programs, and interested and active consumer groups. Government initiatives play a significant role in helping to implement some of these programs.

Conclusion

Up to 5% of women who attend a GP have an eating disorder (Hay, 1999). The GP therefore, has a crucial role to play in all aspects and levels of intervention, from early detection to implementation of treatment and management, through to reviewing and monitoring the patient on a long term basis. However, effective management cannot occur in isolation from specialist services and other health professionals.

An important factor in the successful treatment of eating disordered clients is the availability of GP training in all aspects of care: from early detection and basic intervention principles to specific nutritional and psychological therapies. Time and remuneration issues also need to be considered in general practice as consultations can often take up to an hour. Including the GP once specialist services have finished or the patient is discharged from hospital is important to the continuing management of these patients. Patients who are treated in the public system require a better range of specialist services, particularly in dietetics and psychology, provided by professionals who are specifically skilled in treating patients with eating disorders. It would be useful if a resource directory could be developed and distributed to GPs. Finally, it would be beneficial for these patients if further support could be offered to GPs for educational opportunities, such as teleconferencing, service delivery development and implementation.

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Appendix 1

Don't Miss an Eating Disorder Diagnosis!

Aims Of This Flyer:

1. To increase GPs' awareness of eating disorders
2. To increase rates of early detection of eating disorders

Why Is This Important?

1. GPs are in an ideal position to detect eating disorders early
   - ⇨ Up to 5% of women attending a GP have disordered eating
   - ⇨ In the 5 years prior to diagnosis, people with eating disorders present to GPs *more frequently than other patients* of a similar age, background etc.
2. Earlier diagnoses for eating disorders are associated with better prognoses!

Warning Signs- *Please consider an eating disorder!*

Physical Signs

- Menstrual changes or irregularities.
  - ⇨ Irregularities eg. delayed menarche, amenorrhoea
- Eating Patterns
  - ⇨ Restrictive eating
  - ⇨ Vegetarianism
  - ⇨ May or may not purge food
  - ⇨ Fear of being fat
  - ⇨ May be undernourished
  - ⇨ Calorie counting
- Drug/ self abuse
  - ⇨ Use of appetite suppressants, laxatives, diuretics
  - ⇨ History alcohol/ drug abuse
  - ⇨ Other forms of self harm
- Poor dental health
  - ⇨ Gum disease & enamel loss
- Somatic complaints
  - ⇨ eg. G.I. disorders: intolerance to foods, food allergies, bloating, constipation
  - ⇨ tiredness
- Weight Patterns
  - ⇨ Unexplained changes in weight
  - ⇨ Underweight
  - ⇨ Shows concern regarding own weight
  - ⇨ Dieting to lose weight
  - ⇨ Frequent self-weighing
  - ⇨ Body Image disturbance
- Excessive Exercise
- Feeling cold & poor circulation
  - ⇨ Downy hair growth on body (advanced anorexia)

Psychosocial Signs

Psychological

- Major/ traumatic life events or changes
- Tend to perfectionism & self-criticism
- Life centres around food & need for control
- Feeling out of control, helpless, lonely
- Increasing isolation & loss of friends
- Depression & irritable/ moody
- Obsessive Compulsive Disorder & anxiety common

Historical

- Family/ personal history of eating disorders
- History of sexual abuse
- History of depression, anxiety disorders
- History of self- harm

Family Patterns

- Enmeshed parents
- Often described as 'perfect family'
- Conflict avoiding *or* chaotic/ disengaged

Central Sydney Division of General Practice

Eating Disorders: Classification

Anorexia Nervosa- diagnostic criteria (DSM-IV)

- Refusal to maintain body weight for age and height leading to body weight 15% below expected; or Body Mass Index (BMI) of 17.5 or less
- Intense fear of gaining weight or becoming fat, even though underweight.
- Body image disturbance, strong relationship between body shape and weight and self evaluation, or denial of the seriousness of the current low body weight.
- Amenorrhoea in postmenarcheal females.

(ie. the absence of at least 3 expected consecutive menstrual cycles)

Bulimia Nervosa –diagnostic criteria (DSM IV)

- Recurrent episodes of binge eating characterised by both of the following:
  1. Eating in a discrete period of time (eg., within any 2 hrs) more food than most people would eat during a similar period of time and under similar circumstances.
  2. A sense of lack of control over eating during the episode (eg. A feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviour to prevent weight gain, such as self induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise.
- Binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- Self evaluation is unduly influenced by body shape and weight.
- Fear of gaining weight or becoming fat.

Eating Disorders Not Otherwise Specified

Includes serious eating disorders that do not meet the full criteria for anorexia or bulimia such as Binge Eating Disorder which has many similarities to bulimia but the person does not regularly use inappropriate compensatory behaviour (eg. purge food). Many more people will fit into this category than those who meet the diagnosis for anorexia or bulimia.

Reference: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, Washington DC, 1994.

Part IV: Consumer Voices

You are what you eat – I am nothing – so I will eat nothing. (comment to a Lifeline counsellor, 1995).

It's useless going to a GP who isn't sympathetic or hasn't had much experience with eating disorders. They just say to the parent: 'she'll grow out of it' or 'it's just a stage in her life, don't worry about it' (consumer comment from Gaskill, Chapter 16).

Our experience tells us that there is a great deal of misinformation in the community, including the professional community, about eating disorders and related nutrition and treatment issues…there needs to be a more planned and adequately resourced approach to community education (Blair, Chapter 19).

Chapter 16 – At-risk Industries: Whose Responsibility?

Deanne Gaskill

To be a successful woman, you have to be thin, it has nothing to do with dance or gymnastics or whatever [former bulimia sufferer and secondary school teacher].

Background

In 1995, the Health Advancement Branch of Qld Health requested a report of current literature, policies and programs in relation to body image, sex role stereotyping and disordered eating behaviours (Sanders, Gaskill & Gwynne, 1995). The report served as a framework for the structure, content and stakeholder involvement of the first, intersectoral strategic planning forum held in Australia regarding eating disorders. The section of the Report that follows, incorporated the views of a number of focus groups (for further detail see Sanders, Gaskill & Gwynne, 1995) comprised of students, teachers, coaches, instructors and dietitians from secondary and tertiary education, private dance studios, and sporting/gymnastic associations.

Body image stereotyping: whose responsibility?

All participants agreed that the issues surrounding body image stereotyping were complex and multifactorial. Many acknowledged that the issues must be considered in their historical context, for example, changes in women's fashion, that *there was more of a voluptuous look in the 80s compared to the 90s*, and the emergence of the health and fitness industry. Each participant had their own perspective which reflected occupation, personal interest, life experiences, or position in the community. Secondary school students for instance, were somewhat overwhelmed by the issue. Although they acknowledged the subtlety of media images and so-called societal norms, they were at a loss as to why so many in their age group had an eating disorder:

> *I don't know where it's all come from. It's something I've just grown up with and it's always been drummed into us: thin is beautiful.*
>
> *It's hard to know what causes it. It might be an attention thing or a self punishment thing.*

There was a sense of frustration from many of the dance students who believed that food and attention to body shape began to take over their lives primarily from the time they enrolled at a dance school. All identified that aspiring to classical ballet was probably the most difficult of all. There was a sense that an emphasis on ultra thinness was a peculiarly Australian phenomenon. A number of dance teachers agreed.

> *Recently the Australian Ballet Company were here and students watched them rehearse. The dancers looked ill, like thin, thin, thin! If [students] have aspirations to get into the ABC, they can see quite clearly that they would have to be 40 kg. So it doesn't matter what the teacher says to them about healthy eating and body weight etc [dance teacher].*
>
> *Our role models are professional ballerinas and really, they look shocking!*
>
> *So what happens is, you go in to see a ballet and you come out feeling really depressed.*
>
> *If you're female you have to be a skeleton!*
>
> *It's mainly in Australia and mainly classical – overseas dancers can be on the thin side or slim but they don't look ultra thin or sick looking [dance students].*

Other dance students and teachers spoke of the unrealistic expectations placed on children and adolescents alike. For some teachers, it seemed that this was their first opportunity to talk about their experiences and concerns and seemed positively cathartic.

> *I have a great concern at the number of students I have who believe they have a weight problem. I mean they might have a weight problem if they were a member of the Australian Ballet but the reality is the majority of them aren't. So they become obsessed with the fact they must be a certain weight when it's totally unnecessary because most of them are either going to end up teaching, and you don't have to be thin like that, or joining alternative type companies where body shape and size isn't such an issue.*
>
> *We see kids as young as 8, 9 or 10 who are already obsessed by how they look and the parents too – it's not just the kids. They're being compared by their parents with little so-and-so. And then when these kids hit puberty and see what they think are awful things happening to their body...[dance teacher].*
>
> *I was about 5'5" and under 47 kg when I was 16. I was going to a particularly strict ballet school at the time and "thin was in"! [female dance student].*

There were differing views regarding how much responsibility dance teachers should take, how much 'power' they had. One individual stated, *there's only so much that I can do, I only have them for three hours a day. They have parents, not that I'm shirking any sort of responsibility, but the responsibility is not mine.* Others took the view that because students coming into dance are at an impressionable age regarding their body image, therefore dance schools must be held accountable.

A different perspective again was put forward by a dietitian in the group:

> *We coach them to be perfectionists in areas that specifically relate to their sport and if they've got that nature where they're going to be good at that sport and they're perfectionists, and that's one of the reasons they're good, then it's very easy (for them) to take everything to the perfectionist stage and that includes their eating.*

It was generally acknowledged by both sexes in the focus groups that male dancers were stereotyped as homosexual. Nevertheless, the male dance students agreed that if counselling was made available, there was a greater need for it in the area of eating disorders than in dealing with sexual stereotypes. Further, there was not the same sense of competition among male student dancers compared to their female peers. If anything, male dancers had to contend with their friends' jibes about *skinny female dancers*.

> *For guys, there's not the same sense of "body competition"... It's not as tough for guys to get in (to dance)....When guys find out that I'm wanting to be a dancer they'll have a dig about how small the girls are and how skinny they are.*

Carrying excess baggage – in public

Almost without exception, students of dance, teachers, and those associated with sports training indicated that the pressure placed on students to perform *par excellence* was intense beyond belief. The pressure to perform, irrespective of the activity, always emphasised body shape and size. Whether student, teacher or coach, all participants could relate to a scenario whereby an individual felt singled out in front of their peers and in the case of dance students, walls of mirrors. For different reasons, all could relate to embarrassing experiences, often at an impressionable age.

> *You notice the changes yourself but still the teacher might point out "you're carrying excess baggage here and there!" It's all about looking pleasing, you look towards role models and there are some who look quite unhealthy in the dance world - and manikins in the store too.*

> *...and even my swimming coach would notice any extra weight. You'd get there, and he'd push those people really hard...[female secondary school student].*

There was agreement that comments such as 'carrying excess baggage' and 'pull in your tummy' were problematic. However alternative phrases such as 'lift your tummy' now favoured by some of the dance teachers seemed equally difficult.

> *...the littlest things said by teachers (can have devastating effects). Mainly girls get really upset 'cause they're so desperate to make it [male dance student].*

> *...and you stand there, and there's all these girls in leotards and tights and there's a mirror in front of you - and there's all this competition, you know? [female dance student]*

> *One of my friends was nearly full time at another studio and she's quite a stocky sort of girl, and she just knew that she'd never get anywhere in ballet if she remained that way so eventually she really started dieting very rigidly to the point where she was eating very minimally and she was almost passing out or fainting in class because she didn't have the energy anymore. And yet, we were probably reinforcing her eating disorder by admiring how thin she'd got. So when you're in that situation, you almost don't see the negative. You accept all the negativity because she's still achieving the goal [female dance student].*

Students who had taken up dance or a sport of some kind considered their family to be supportive but sometimes overbearing. For some, it seemed the amount they ate was always being monitored either because they were eating too little, or eating too much. While students could understand the reasons underlying their family's concern, at times it was a source of frustration and occasionally placed an undue strain on relationships.

> *My mum's always watched everything I ate. She's trying to help but it gets really annoying sometimes. Things like: "Do you think you really need that?"....because she knows how much I want to make it. She's not really making my weight a big issue, she's just trying to guide me I think....like she wants to help, but I still get angry [female dance student].*

> *Mum keeps a close eye to ensure I'm eating properly! But she knows it's up to me and my own strength of character. In the final analysis, it's me who makes the decisions [female dance student].*

> *...oh, you're not eating much, come on, eat up! Eat up! But I'm just a medium or average eater, I just can't eat any more. Anorexia probably crosses her mind [female dance student].*

I don't know what to say – but I think she has an eating disorder

All participants had personal experiences of friends, students or colleagues who they believed were anorexia or bulimia sufferers. The majority of participants, which included all the students and many of the dance teachers, indicated varying degrees of difficulty with what to say or do when they became aware that their friend or student was likely to have an eating disorder. This was particularly evident for students:

> *There's a lot of awareness about eating disorders these days...we've been taught about it at school. At school, we have so many people with eating disorders and you don't know what to do. Like, one girl has been really thin for years now...she's weak, she's not the same any more. She used to be really good at sport and now she can't even do that.*

> *...and you don't know what to say 'cause you're not a psychologist but then the counsellors don't know what to do either. It's really up to the parents... [secondary school students].*

Most teachers and coaches could identify with the concerns expressed by students. However, the way in which they responded to at risk individuals varied. This reflected one or more factors: occupational background, employer's policy and procedures, professional code of ethics, and past experience.

One of the physical education teachers who had come in contact with students with an eating disorder at two of the secondary schools where she had worked, identified how the issue is *very much handled under wraps*. At one of the schools, a constant frustration for her was the policy that only one or two teachers could be responsible for the student with the eating disorder: *Yet, as a physical education teacher and coach I wasn't told what I should or shouldn't be advising or saying to this student.*

These experiences were shared by most of the dance teachers. One teacher though, had had a particularly distressing experience early in her career (an abusive father) which still influences how she responds to students *even when an abnormal situation is suspected*. Another teacher from the tertiary education sector had been informed that students were legally within their rights to lodge a formal complaint of harassment if a staff member suggested that they might have an eating disorder.

In the health and fitness industry, regular attendees of gyms frequently form support groups and may notice a member changing their eating patterns. They approach a fitness leader because *they don't know how to handle the situation or what to say*. Hence, it is important for fitness leaders to be aware of the situation.

> *There's no point in refusing clients access to the gym as they will find another and then you've really lost them, you've lost contact with them. Keeping that contact is virtually your only lifeline to try to get them help, or at least direct them into a program where they don't lose too much fat and won't put on too much muscle – more of a toning program...*

The dietitians who specialised in sports nutrition found that often, their first contact was a parent. Their approach usually took the form of first, discussions about healthy eating and how the client felt about themselves. If a general practitioner hadn't been consulted then the next step usually included writing a referral to the family GP: *It's not a nutrition problem really, it's a psychiatric problem*. Alternatives, depending on the circumstances, included referrals to sports physicians or psychiatrists with experience of eating disorders and who bulk billed. Although part of the training program for athletes usually included a sports psychologist, there was general agreement that such individuals don't have a background in eating disorders. As one participant commented:

> *It depends on whether the person was a psychologist first and then developed an interest in health and fitness or a physical education person who became a psychologist.*

> *The students get upset when they reach the conclusion that a friend has an eating disorder and they don't know what to do or how to behave. And what should they do, if anything? [secondary school teacher].*

Most participants believed some form of protocol to deal with situations such as those outlined above needs to be developed. Some of the secondary dance institutions are currently developing these and recognised that each case must still be dealt with on an individual basis. The importance of maintaining contact with the parent or guardian if a problem arose was also acknowledged. For most dance schools however, there is very little, if any, self regulation.

> *People work and function in small businesses so they don't have the day to day professional interaction with their peers. In the large cities like Brisbane several of them do, but there's just such a lot of opportunity for people who are unaware and a bit afraid of the situation "to not want to know" [dance administrator].*

There was some discussion about whether recognition of eating disorders in the dance industry was any different in Brisbane or Queensland compared to other states. One dance teacher/administrator could cite a number of instances where dancers have jobs interstate *then come back here and can't bear what's going on around them*. Alternatively, one of the dietitians in the group has ballet dancers who come back from interstate to see her in their holidays *to try to deal with what they've had to put up with down there – the pressure!"*

Food, glorious food: I think I'll have a diet coke instead.

With the exception of the secondary school students, a consistent theme from participants was the emphasis placed on diet and weight watching. For the dance students particularly, it was part of their life. The teachers/coaches and dietitians agreed and were concerned about the impact this had on the students' social life.

> *Most of the kids who do dance very seriously are concerned with any decision concerning food...they will never have an ordinary soft drink, they'll have a diet coke. They can't even go to a party and really enjoy themselves without feeling guilty [female dance teacher].*

> *You go to buy something and you say to yourself, should I or shouldn't I, and it's really awful, particularly when you're with friends [female dancer].*

> *And like when we're eating our lunch, we're always talking about food, and talking about weight and stuff....and if you see somebody else watching their weight you think, we'd better do it too, because we're bigger than them [male dancer].*

> *I don't find that my other friends watch their weight as much [female dancer].*

Most participants identified an urgent need for teachers, coaches and instructors to become more aware of the issues associated with eating disorders. *A lot of the dance and studio teachers don't have a lot of background in the area and therefore don't know just how careful you've got to be [dance teacher/administrator]*. The importance of this statement was highlighted by a group of dance students who knew that one of their peers was quite severely anorexic. On reflection, the group would have appreciated some guidance about how to deal with the situation and have subsequently asked for talks on the topic generally. However, for this group, at that time, the situation was made worse when coincidentally, their instructor organised a visit from a dietitian: *And the dietitian did this thing of going round the class and saying: How many kilojoules did you have today? I thought that was pathetic!*

Nevertheless, recognition was given to the *danger that in trying to be helpful, the counselling or advice could in fact be destructive [ex fitness instructor]*. In pondering the question of what is appropriate to say to a student who a teacher might be worried about, one experienced person suggested the importance of establishing rapport by focussing on positive attributes. The example given from this person's day to day work experience follows:

> *Once upon a time I might have taken the student to one side and asked, for example: "Have you had any breakfast today?" Now I'm more inclined to offer a positive comment like: "That's a pretty leotard you're wearing." You may not be able to do a lot for them but you can do a lot against them. That's why I think it's important to build rapport so that there might be a time when the student is ready to talk about it.*

The millstone around their neck

> *I just wish it would go away and stop following me!*

There was a sense from all participants, but from dance students especially, that eating disorders in one form or another was following them, that there was no escape, and that being aware of food and one's body shape was a necessary evil towards goal achievement. It was recognised that these 'obsessions' could be sporadic, however for some students, severe dieting seemed the only way forward.

> *There seem to be phases that groups go through, like where they're really obsessed with weight and that everyone's eyes are on you. But then after a while, you learn to get past it, that is, most of us, through an inner strength or willpower. Yet so many people give in to it – like having an eating disorder is the easiest way out rather than doing the work.*

I just think that we're under enormous pressure and I really wish that it wasn't there. Some days I just get absolutely sick of it because you deal with it everyday (as a dance student). Why can't I just dance and be accepted for what I can do! And yet on the other side, you know that for some forms of dance or positions you find it a lot easier if you're carrying less weight – the higher the leap and so on. If you're carrying too much fat it just gets in the way.

While some students clearly articulated their sense of frustration with the whole business, they also recognised that it was extremely difficult to avoid paying attention to their weight.

> *As a dance student, I'll be perfectly honest. I'm very conscious of what I eat, particularly if I've got an exam coming up, but I try to be very sensible about it [female dance student].*
>
> *It's really hard because you're supposed to have that aesthetically pleasing body [female dance student].*

For some students, the most disturbing situation is when they have a friend who they perceive has an eating disorder but denies it. *They want the confidence from everyone else that they're not fat, they just want reassurance from other people [male dance student]*. Students also distinguished between those who "are doing it for attention" and those 'who are doing it for themselves', that is, some inner motivating factor. According to students, the latter is *the scariest situation because that's the harder one to cure – and it can break up friendships too because they're just so determined [dance students]*.

Last reflections...

A number of views about the issues surrounding body image, sex role stereotyping and eating disorders have already been noted. However, what hasn't been referred to are comments made by some participants that suggest a sense of frustration, confusion, feeling overwhelmed or even defeated. It may be that participants' comments reflect the inadequacies of current treatment and prevention programs.

> *It's such a touchy area, and honestly you feel as though you're hitting your head against a brick wall.*
>
> *It becomes a competition between them as to who can do it (purging) for longest. They swap notes about how easy this way is versus that way...*
>
> *There has to be a tendency towards it. It's not normal to go around sticking your fingers down your throat.*
>
> *I think health professionals are quite happy for it not to be their problem.*
>
> *It's useless going to a GP who isn't sympathetic or hasn't had much experience with eating disorders. They just say to the parent: "she'll grow out of it", or "it's just a stage in her life, don't worry about it!".*

In conclusion, a number of recurring comments reflected the following: First, an urgent need for the development of education programs for teachers, coaches, instructors, and counsellors from all areas of dance (high priority); secondary schools; sporting and gymnastic associations; and tertiary education. It was suggested that in-service programs not only provide facts and figures about eating disorders, but also make provision for engagement in informed discussion about how best to support at-risk students, their peers, and themselves. Second, the promotion of community education campaigns to 'de-mythologise' eating disorders and simultaneously address the complexity of the issue. Third, availability of 'people to talk to' who have personal experience of anorexia or bulimia. Fourth, that the issues *be discussed more openly and policies or a set of steps be put into place in all (discipline) areas – it will give us something concrete to follow [dietitian].*

Finally, and as a result of the personal experience of a former bulimia sufferer and secondary school teacher who was commenting on some of the currently used treatments for eating disorders: *Why should you punish someone for a compulsive disorder?*

Community Organisations

Introduction

The three community organisations represented in this book were asked to contribute because they are relatively stable organisations and have received funding from their State governments for at least five years. South Australia, Victoria and Queensland are the only states to use the strategy of funding community organisations to help address this significant public health issue.

While in other states, namely, Tasmania, New South Wales and Western Australia, telephone numbers are available via the *White Pages* ™ *OnLine*, there are no listings for the Territories. With one exception, all State listings are located under the key words of either 'eating disorders' or 'anorexia'. The alternative is 'eating issues' listed for *ISIS: Centre for Women's Action on Eating Issues.*

Although the Editors recognise that contact numbers and addresses for individuals and community organisations frequently change, we have been requested to include the following details which were correct at the time of going to print.

New South Wales

Eating Disorders Association of NSW Inc
Phone (02) 9899 5344

Queensland

Eating Disorders Association (Qld) Resource Centre
Phone (07) 3876 2500
http://www.uq.net.au/eda/

ISIS - Centre for Women's Action on Eating Issues
Phone (07) 3392 2233
http://www.isis.org.au/

South Australia

The Anorexia & Bulimia Nervosa Association
Phone (08) 8212 1644
http://www.ozdir.com/abnfv/

Tasmania

C/- Community Nutrition Unit
Phone (03) 6222 7222

Victoria

Eating Disorders Foundation of Victoria (formerly known as the Anorexia & Bulimia Nervosa Foundation of Victoria)
Phone (03) 9885 0318
www.ozdir.com/abnfv/

Western Australia

Eating Disorders Association of WA Inc
Phone (08) 9221 0488

Chapter 17 – The Anorexia and Bulimia Nervosa Foundation of Victoria

Karen Elford

> *Sometimes all we need is to talk to someone about what is going on.*
>
> Comment by Telephone Support Service user, 1998 ABNFV Customer Satisfaction Survey.

Introduction

The Anorexia and Bulimia Nervosa Foundation of Victoria (ABNFV) was founded in the early 1980s with the purpose of supporting those affected by anorexia and bulimia nervosa, and of informing the community about eating disorders. With the emergence of binge-eating disorders and eating disorders not otherwise specified (EDNOS), the Foundation's mission statement later expanded to include anorexia and bulimia nervosa and other eating disorders.

The ABNFV is not a medical service, nor is it a provider of therapeutic programs. It is a non-profit, community based support service endeavouring to fill a gap - to meet the needs left unaddressed by clinical services and the rest of the health service system.

The Foundation's primary function is to provide support, information, and referral options to any affected person. This includes just about everyone - individuals with an eating disorder, their families, friends, workmates, employers, teachers, youth workers and the whole range of health practitioners. The list of those with a need for information and support goes on.

As an independent and unaligned service managed by a voluntary Governing Council comprising consumers, parents, health practitioners and interested laypeople, the Foundation is also well positioned to act as a lobbying agent and to advocate on behalf of consumers.

The original focus of the ABNFV's work was on providing support to those who were the most in need, that is, the very sickest. With funding allowing for only one half -time worker for the first several years of the Foundation's life it was decided, rightly, that the energy of the organisation must go to those who needed it most.

Now, one and half decades later, support is still offered to individuals and families who struggle to overcome these disorders, but with an increased understanding of the value of preventive and educative work. Rather than simply providing information on how to recognise an eating disorder, workshops and presentations focus, for instance, on the need to increase resilience, and encourage young people to develop a critical awareness of the influences and pressures to which they are subjected.

Individuals and families are actively encouraged to seek out assistance from appropriate health practitioners, however, one of the underlying philosophies of the ABNFV's work is that there are different paths towards recovery. Our role is not to promote any one treatment option ahead of another, but to encourage people to know about, and understand what their options are in an unbiased way. An informed and appropriate decision is only possible with access to accurate information, provided in a supportive and respectful way.

Hopefully, with information and encouragement people will be able to move forward in some way, whether that is in the pursuit of therapy, or in finding different ways to relate to an eating disorder affected person.

Support, information and referral service

> *Having spoken with the support worker we confronted the problem straight away, and I feel that if I had not had that discussion we still may be wondering what to do.*
>
> Comment by Telephone Support Service user taken from 1998 ABNFV Customer Satisfaction Survey.

The provision of the telephone counselling, support, information and referral service is a major part of the Foundation's work (almost 70%). The demand for this service is great, and it could not continue without the input of the volunteers who staff the helpline with the supervision of permanent staff. The need for information from those affected by eating disorders is constant, not just for those experiencing an eating disorder, but also family members, friends, concerned teachers, employers, partners and co-workers. Individual needs vary, but what remains consistent is the need for basic information, and the answer to that universal question "What do we do now?" Available Monday to Friday between 9.30 am - 5.00 pm, the service responds to a variety of callers and situations: the scenarios are unlimited. Telephone support workers may be called upon to provide something as straightforward as a referral to a general practitioner who has a better than average understanding of eating disorders; to discuss options and strategies with a distressed and frustrated caller after having listened calmly and non-judgmentally to their story; or just to listen to someone who is finding it hard-going to get through the day and simply needs to talk about it.

During 1998-1999 the support, information and referral service responded to more than 4700 requests for assistance.

Support groups

> *It's a relief to know you're not alone. The experiences of others, who have been where you are now, are very helpful.* Comment by Relatives & Friends Support Group attendee taken from 1998 ABNFV Customer Satisfaction Survey.

> *I was challenged by other people's experiences – it helped me to identify patterns of thinking in myself that were not helpful.* Comment by Sufferers Support Group attendee taken from 1998 ABNFV Customer Satisfaction Survey.

Separate mutual support groups for people with an eating disorder, and for relatives and friends are offered on a weekly basis at the ABNFV premises. Voluntary convenors aim to promote a safe and caring environment where group attendees can share concerns, identify their commonalities, and learn from each other's experiences. Additionally the Relatives and Friends group benefits from the presence of a range of health practitioners (usually ABNFV Governing Council members), who provide an extra resource for the group. From time to time Combined groups are held, so that each group may learn a little more of the experiences of the other. All groups provide an opportunity for information sharing, increased understanding and mutual support. They aim to help to reduce the sense of isolation felt by many people affected by eating disorders. Families and friends are relieved to be in the company of others who understand these feelings of frustration and bewilderment because they too have experienced them. The knowledge that one is not alone is encouraging and potentially empowering.

Current ABNFV resources do not allow us to provide support groups at locations other than our office. This is a frustration – we believe there is a demand for more groups, particularly in regional and rural areas. A handful of support groups do operate across the state, though their success often hinges on the energy and often voluntary commitment of one individual. This is problematic: there is a high risk the group will collapse should the key person's ability to support and resource the group diminish. Additional funding for the employment of another worker would allow us to actively resource and support other groups. Approximately 450 people access ABNFV support groups each year.

Resources

> *What I read was relevant to my problem and how I feel – the facts helped me understand, and what I have to do to overcome this obstacle.* Comment from user of written ABNFV information taken from 1998 ABNFV Customer Satisfaction Survey.

Six editions of the *Spread Your Wings* newsletter are produced and distributed each year. Available by subscription, copies are also provided on a complimentary basis to the major providers of in-patient and day program eating disorder services. Contributions from readers feature regularly, often in the form of Recovery Stories providing hope and inspiration to others.

The Foundation also provides a range of other information brochures and written resources:

- Information brochures *Anorexia and Bulimia Nervosa and other Eating Disorders, Information on Eating Disorders for Families and Friends,* and *Eating Disorders, What's the Story?* (for younger people).
- Body Image and Eating Disorders: A teacher training manual.
- A 40-page booklet, *Information on Eating Disorders for Health Practitioners* originally produced in 1997, was revised and updated early in 1999.
- *Recovery Stories,* a 30-minute video featuring the stories of two young women recovered from an eating disorder.
- An activity kit for schools is in development.

The ABNFV resource centre includes more than 250 books, largely donated or purchased with donated funds. Books are accessible to anybody on site, and available for borrowing by members. A reference collection consisting of research papers, media clippings and other items of interest is regularly used by students at all levels and from a range of disciplines.

Community education

Numerous presentations and community talks are provided in response to requests from schools, community groups, and other workers. We try to respond to as many of these as possible, although we are limited to the metropolitan area, and by the demands of the service workload. Each year during Body Image and Eating Disorders Awareness Week the Foundation aims to mount a large profile-raising activity, while also meeting the needs of the public for an informative and positive event. The B.U. (Body Unlimited, Be Yourself) Benefit, a music and comedy activity targeting younger people was the focus of the Foundation's awareness raising work for 1998. Timed to launch National Body Image and Eating Disorders Awareness Week, the event aimed to promote positive body image messages, and featured prominent female performers, all of whom subscribed to the message *'Celebrate your natural shape'* in their own way.

During Awareness Week 1999, 340 people attended a public forum featuring a range of speakers while 35 people dropped in for a 'chat' at the ABNFV Open House.

Professional study group

Convened by the ABNFV, this network, open to any member working in the field of eating disorders, meets bi-monthly to discuss issues of interest. Network members include social workers, therapists, general practitioners, dietitians, counsellors, youth workers and others who attend in an effort to broaden their knowledge base and network in an informal setting. Topics discussed have included: recent research, sub-clinical eating disorders, cognitive behaviour therapy, dietitians' approaches, adolescent depression and links to eating disorders, siblings of females with eating disorders, ballet schools' approaches, strategies for clients with long term eating disorders, overviews of treatment programs in Melbourne and interstate, book reviews for general and specialist use, guidelines and strategies for families and friends, inpatient re-feeding programs, and reports from international eating disorders conferences.

Networks and links

Working cooperatively with other agencies and individuals is essential for any small organisation. The ABNFV is actively involved with a number of networks including the Carers of People with a Mental Illness Network, and the Mutual Support & Self-Help Network (psychiatric disability support sector). These two networks also provide a forum for regular contact with representatives from our funding body. The peer support gained from interacting with other like agencies is vital for workers in small organisations.

Links with other organisations and networks also enable the provision of services otherwise beyond our scope. For instance: the production of the *Body Image and Eating Disorders Kit* in conjunction with Women's Health East, and the provision of an eating disorder seminar at the 3rd State Conference for Carers of People with a Mental Illness.

Workshops and training

Requests for information from professional sectors of the community have resulted in the development of specific resources. Workshops and information sessions are tailored to specific requests. A series of workshops and a training manual for teachers were developed with the assistance of a grant from a philanthropic trust. In response to demands from the fitness sector, and with the help of a dedicated volunteer with industry experience the ABNFV received accreditation from the Australian Fitness Accreditation Council for a workshop for fitness workers, coaches and gym staff.

Funding

The ABNFV is funded as a psychiatric disability support service through the Mental Health Branch of the State Department of Human Services. Additional minimal revenue is generated by memberships, the sale of ABNFV resource materials, and fees for speaking engagements and workshops. There is no cost to users of the information and referral service or those attending the support groups, although we do request a gold coin donation to help offset the cost of providing the groups.

Although our funding is minimal ($100,000 annually), relatively speaking we are quite well off: most states have no similar funded organisation, or are funded well below the levels of the Victorian and Queensland groups.

With funding allowing for the paid employment of 1.8 equivalent fulltime staff only, the ABNFV's ongoing ability to meet service demands is wholly dependent on the contributions of volunteers; as support group convenors, as telephone support workers and in a multitude of other roles. An integral part of the Foundation, these unpaid workers bring a range of experiences, expertise, skills and knowledge, greatly enriching and enhancing ABNFV service planning and delivery. All have a special interest in eating disorders. For some, their interest in helping others has developed through their own personal experience of an eating disorder, now recovered, or as a family member or friend of someone affected by an eating disorder. Others may be health practitioners or students with a specific interest in the field of eating disorders. All volunteers are reimbursed for travel and other incidental expenses by means of an honorarium. Support group convenors attend a two day groupwork training course at the expense of the Foundation.

A sympathetic landlord means that the cost of renting our cosy, if somewhat shabby 'home' is affordable. To pay commercial rents would mean cutting back on salaries and loss of workers' hours. Larger premises in a more central location, with a higher street profile is desirable, but beyond our means.

Demand for services and nature of this demand

The public demand for existing services remains steady. During 1999 the Foundation provided services to more than 7000 individuals in total. This includes those assisted by the information and support service, participants in the support group meetings, and those who attended an educational activity offered by the Foundation.. It is probably fair to say that our government funding body certainly gets good value for the $100,000 it provides us with annually.

Regular planning days result in no shortage of possible new projects and initiatives. Unfortunately, though our 'wish list' of activities and plans for the future seems boundless, the reality is that without an increase in resources our ability to grow and provide new or expanded services is limited. At minimum, a range of free written resources is available to anyone who might benefit. Hopefully after speaking with a telephone support worker, or dropping into our office for a chat people will feel empowered or encouraged to go on to the next step, whatever that may be for them – perhaps coming to a support group or seeking more information about a treatment option. For many people however, the 'magic answer' or the effective, inexpensive treatment they desperately seek does not exist, and the reality is that it may take them some time to find the services they need.

Public awareness

Public awareness of the existence of the organisation is an ongoing issue. Raising the awareness of the service as an available community resource is continually problematic without a marketing budget. Lifting the profile of eating disorders in a positive and empowering way is often equally difficult. All too often media interest is accompanied by a request to interview and photograph a "victim" of the disorders, preferably someone as visibly underweight as possible. We don't do this. It is unethical. As well as exploiting someone who is clearly unwell, it only perpetuates the public preoccupation with sensationalist dramas, and does nothing to convey a positive message of hope and recovery to those in the community who do need help, and who do need to see that recovery is possible. Focussing only on extreme examples of suffering also invalidates the many thousands of women and men we believe struggle with sub-clinical eating issues on a daily basis.

Our perception is that the general public, and indeed many health practitioners, have a poor understanding of the seriousness of eating disorders as a major health problem. Their level of understanding of the potentially disastrous impact on the quality of life of those suffering from these disorders, and their families is similar. It is not rare for us to hear that upon making contact with, for instance, an area mental health service, the duty worker has told the caller that "we only treat serious mental illnesses here".

Common issues faced by users

For carers and those with an eating disorder there are many common issues. The most pressing is their need for, and the service system lack of, affordable, accessible, and flexible options along the whole treatment spectrum. For those without private health insurance, access to eating disorders programs in the public health system generally involves a waiting list with the very sickest (rightly) given priority. This can mean that admission to programs comes much later than it should; by which time the person's condition has probably deteriorated even further. Access to in-patient, out-patient and hospital day programs, consultations with public and private psychiatrists, and access to community health services (if one is lucky enough to live in the catchment area of a health service with a staff member who knows something about eating disorders) is similarly fraught.

Even with private health insurance the search for treatment can be frustrating as finding the right therapist is often a hit and miss affair. It is not unusual for a person to have experienced therapy with several therapists before happening upon the one that is right for them. In the mean time telling and retelling their story is wearing and disheartening, and every unsuccessful therapeutic relationship adds to feelings of hopelessness or of being untreatable.

Treatment options in the non-metropolitan area are minimal; accessing appropriate services often means travelling to the city, and a further disruption to the lives of those already struggling to keep things together. Families' needs for basic information relating to how to best help their loved one with an eating disorder is another major and common issue. Families often lack information, confidence and the basic communication skills which can make their life with an eating disordered person more manageable. Access to appropriate, practical information and resources, significantly improves their coping abilities. With encouragement they can see that recovery is possible, and that there are practical steps that they can take to help the affected person towards the goal of recovery, while at the same time increasing their own resilience to the family pressures created by the disorder. Families, for a variety of reasons, are not always included in the treatment process.

Mental illness and stigma go hand in hand, and eating disorders are no exception. Although the general level of awareness in the community has improved, eating disorders are generally still quite poorly understood. Notions that the disorders are somewhat self indulgent, a precious adolescent behaviour to be grown out of, and that they do not constitute a serious mental illness, linger. For families, talking about the situation openly with others, even close friends, can be difficult. Feelings of shame, embarrassment and the idea that fault lies with the family abound.

Commonly, people with an eating disorder tend to withdraw from their social world. Situations involving food are avoided and relationships with others suffer as a result of the mood swings, depression, irritability and personality changes often associated with the disorder. In severe cases where the person's ability to hold a job or continue attending classes is compromised, the isolation is compounded. Support groups, and the provision of the telephone support line go some way to counter this.

Chapter 18 – The Anorexia Bulimia Nervosa Association (Inc)

Cina Mastrantone

The Anorexia Bulimia Nervosa Association (ABNA) was established in Adelaide in 1983. ABNA is a non-government, community based organisation providing information, support, and referral services by telephone or by appointment. We have a small resource library, produce a newsletter for members, provide support groups for people experiencing eating disorders, and run groups for parents and partners concerned about someone experiencing this problem. ABNA staff deliver community education in schools, in-service for health professionals, and training for health workers. Organisations such as ABNA fulfil a multifaceted role in the community.

Eating disorders and body image disparagement are by their very nature, silent, personal, and isolating experiences for the individual concerned. This isolation often extends to the person's family and partner. One of the most important roles for ABNA is our ability to act as an entry point to the health system. We are simple to access and not diagnosis driven. This simplicity works, as people can phone or walk in when they are ready and at a time when they may be prepared to address the issues contributing to their eating disorder. This role is important and integral to assisting people who seek help. To some extent, this contributes to prevention in a meaningful way, as ABNA accepts the individual for where they are at, and facilitates their access to the broader health system.

The peer group support offered by volunteers adds another dimension to 'de-pathologising' the experience for the consumer. Frequently, the consumer needs to hear that there is meaning behind their experience, that people do and can recover a better quality of life, that it is not their fault, or their mother's fault, nor the fault of any one individual or institution, and that they have developed this behaviour as a strategy for coping with life. An important dimension to ABNA's work is our ability to involve people who are now well and who have reclaimed their lives from an eating disorder. People volunteering with ABNA are involved as support group facilitators, as community educators, with telephone information, support and referral service alongside the salaried staff. The use of peers through community organisations like ABNA, provides a unique opportunity for mentoring in a way that names the contributing factors to eating disorders but in a manner that is not shaming. In this respect, a significant aspect of the role of peers is that they provide a loud message that recovery is possible. Peers provide an opportunity to witness real, alternative stories to their audience - whether community members or professionals. For people struggling with eating disorders, when at times maintaining hope is difficult, it is hearing others' experiences that sustains them.

Our work bridges the needs of people at different points in their recovery process. People often access ABNA in the early days, and then tailor off during their stay in hospital or counselling in another setting. However, many people return to support groups, use the library, or contact members of the volunteer team to catch up about some of the everyday issues they are grappling with, as they become healthier, both physically and emotionally. Sharing their experiences honours the steps they are taking to recover from the effects of an eating disorder. As workers, hearing success stories also energises and sustains us in our work.

There are at least three distinct groups who access our services. A key group is parents, mainly mothers, who want to discuss their concerns about a daughter who is losing too much weight. Eating disorders are pernicious and develop very quietly over years, with the person concerned not acknowledging that the process is occurring. So it is often other people in their lives who contact ABNA at times when the sufferer has become noticeably unwell, to find out how they can facilitate the person they care about taking steps to get help.

A second group represents individuals with an established eating disorder, usually adults who characteristically are maintaining a high level of functioning by keeping up with work and/or study commitments. Often this group of clients has insight into the range of issues contributing to their sensitivity around food and body weight, but is struggling with societal notions of self-control and perfectionism. When they access ABNA, we are able to provide a starting point by identifying the effects of eating disorders, and acknowledging their sense of shame and failure in experiencing these problems. We also provide information about longer-term counselling or clinical treatment if needed, and printed handouts about the physical and psychological effects of eating disorders. From this point, people will often take steps towards longer-term counselling/treatment or join a support group.

The other significant group accessing the service includes students and health workers. Many health workers use the Association as an information resource centre especially if they are planning programs around body image or healthy eating.

In addition, people from the community access ABNA by telephone to discuss issues they have with their bodies and food. Oftentimes, these people appear to be experiencing depression or anxiety. Others are experiencing exclusion and marginalisation, including being teased or bullied for being larger. Larger people are faced with the need to sustain themselves in a fat phobic world that threatens their acceptance of themselves.

People accessing ABNA often speak of the 'referral merry-go-round', especially if they are not seriously physically compromised but are experiencing other health effects. Access to either free or affordable therapeutic services is a significant issue, as our client group is predominantly comprised of young women with limited incomes who are studying or working in entry-level jobs. Another issue is locating services that are non-psychiatric. Most people I speak to feel very uncomfortable about accessing services in the psychiatric system. This is particularly the case if they are buoyant and getting on with life, but know that they experience emotional issues. Many people hope they will be able to commence treatment or a therapeutic process as soon as they can. We hear about the courage that it has taken to make the initial call to ABNA. However, it is not within our brief to offer treatment services.

There is a need to improve primary medical care for people seeking help for the first time. Often, people are not assessed and diagnosed early, partly because there are no universally used clinical practice standards. Resources for General Practitioners to improve their knowledge and skills in effective intervention for both eating disorders and body image issues are vital. The GP is often the first person consulted and a skilled and appropriate response can mean the difference between implementation of early treatment and the person withdrawing, until a medical crisis forces them or their family to again seek help. Models for this work exist in relation to depression, anxiety, and suicide risk. The specific needs of people with eating disorders can be included in the GP's education.

People at the severe end of the spectrum, who are grappling with serious clinical symptoms, speak of the paucity of rehabilitative services available to them following their discharge from extended hospitalisations. In South Australia, there are no discrete day programs for people recovering from clinical eating disorders. People who are hospitalised may be away from the mainstream for months at a time. Yet the expectation is that they will return home, continue to maintain a safe weight and take up their lives and relationships where they were left off. Unfortunately, the process is not so smooth for everyone. People with eating disorders do not magically recover after one intervention and may require prolonged assistance. Services need to be what the person wants and is comfortable with, affordable and the place and timing of delivery accessible. Increasingly, health care options are becoming privatised, a policy that is driven by market economics, but this further reduces treatment options for many sufferers.

Models of excellence do exist in Australia and are often the result of small multi-disciplinary teams who have developed their expertise through years of experience in treating people with eating disorders. These programs work for many. However, such expert practitioners are frequently in high demand and have little time available to develop resources and participate in training other health professionals. The importance of a range of treatment options being available and accessible cannot be overemphasised. Not everyone with an eating disorder needs or requires hospitalisation and if early intervention is to be successful, realistic choice of quality treatment options is essential.

These are some of the dilemmas that exist in this field and the solutions are not simple. Eating disorders are pernicious and dangerous conditions and sufferers often describe how difficult it is to reclaim their lives from the effects of severe anorexia or bulimia. Authorities need to address resource and skill issues within the health care system to enhance outcomes for patients. Use of telecommunications technology for networking, information exchange and training opportunities has potential. New developments in the consumer movement, in the form of peer education programs may also be worth pursuing for an injection of 'ground-up' expertise from people who have been through the experience. Hopefully, these experts will be incorporated into a range of training forums. Finally, there is a need for structural change in relation to sectors such as the media.

Chapter 19 – Queensland Eating Disorders Resource Centre

Joanne Blair

Introduction

In 1989, the Eating Disorders Association (EDA) grew out of support groups for people with eating disorders and groups for carers whose members became active in community education and lobbying. The Association was incorporated in 1994 and currently has a membership of over 320, still mostly consumers and carers but also a large number of service providers. The EDA was funded through the Mental Health Community Organisation Funding Program of Queensland Health in 1996 to develop and manage a Resource Centre in Brisbane. The Resource Centre has a state-wide responsibility for delivering information, referral and support services to people affected by eating disorders. The service employs a coordinator and an administrative officer on a full-time permanent basis. Volunteers assist with support groups, telephone support, newsletter production and as reference group members for various projects.

Telephone support

The Resource Centre alone, receives about 130 client calls per month, and provides a telephone service for self-help information, crisis support, and referrals. Nearly one third (31%) of these callers access referral information, a further 10% comprise crisis counselling and a smaller number (about 4 or 5 people per month) seek assistance in person. More than half (57%) of the callers are sent information packs through the post.

Support groups

We provide an 11 week facilitated support group which is offered three times per year, but would probably be utilised more often if we had the resources to do so. We are also trying to assist with the development of support groups around Queensland, a need that has been consistently identified in our surveys by consumers, carers and service providers. Two parents facilitate a support group for carers once a month, and we have developed a six week "Family Information Workshop" based on consumer and carer feedback. It has been successfully implemented with input from various service providers, consumers and carers.

Community education

Each month, a 10-page newsletter is produced that provides self-help information, communication of thoughts and feelings, and news about relevant developments or events. A group of consumers meets with staff to generate ideas and plan for newsletter issues. Our library has a large collection of self-help books, journal articles and professional reference books and approximately 30 people each month access this. We are involved in community education with numerous community and professional groups, and we coordinate some low-cost activities for Body Image and Eating Disorders Awareness Week.

Website

The EDA website receives about 42,000 individual visitors per year. It provides information about various eating disorder related subjects, and has an email discussion list called "EDTalk", with over 200 members. The EDTalk members have created their own website called "EDTalk Friends", which contains creative contributions and favourite links. EDTalk is recovery focussed and is a source of some very positive support.

Service delivery and outcomes

Carers – A case study

About 40% of client calls are from relatives of someone with an eating disorder – usually parents of a young female 13 to 25 years old. The first contact with the carer in this case study, who lived outside of Brisbane, was in the month of January. Her 21 year old daughter had been home for Christmas (from Brisbane), and her appearance, changed mood, and isolative behaviour was causing concern. The first phone call started with this mother expressing her concern tentatively, wondering if she was seeing a problem where there wasn't one. The more she talked, the more she let out the fear that she had been suppressing. The more details she recalled the more apparent it became that her daughter probably had well-established anorexia nervosa. We discussed possible courses of action regarding the process of establishing a productive dialogue about the problem with her daughter. This included acknowledging the very real concern that her daughter's health, career and mental state were all threatened by any delay in getting help.

She was given information about sources of assistance for her daughter, and was sent information about helping someone with an eating disorder, as well as a reading list. As this caller was from an area without easy access to the recommended books, she was sent information about how to bring an eating disorder out into the open within a family. This reinforced our discussion and helped her to convey the issues to her husband.

They used this information to practice how they would approach their daughter, and to make contingency plans for how to respond if she denied the problem, reacted with anger, accused them of causing a problem, or made any other attempt to avoid the issue. They called back to clarify a few things, then came to Brisbane to see their daughter and approach her with their concerns. On this first approach, she attempted to deflect them by pointing out a supposed problem with her mother's mental state, but because of their preparation for this, they were able to deal with it calmly.

They were clear, confident and united. They let her know that they cared too much to let it go, even though they acknowledged her right to make her own decisions. They left her with some of our information pamphlets, then went home telling her they would be back to talk again soon. At the end of February we got a call to let us know that their daughter had called them and opened up to them, telling them that she'd had an eating disorder for several years, and knew she needed help. She called our centre for referral information and then arranged an appointment with a private psychologist in two weeks time. It was going to be expensive for her because Medicare doesn't offer this cover, however, she didn't want to wait three months or longer to see a psychiatrist (see for example, Powell and Fleming, 1999)

These parents know that there is still a long road to walk, that there will be times when their daughter will again deny that she has a problem, but they will be able to handle it and support her. They are convinced that without the services EDA has been able to provide, they would not have acted as effectively, and would not have been successful in their approach to their daughter.

Much more difficult, are the calls from parents who were unaware of EDA until their situation was out of control. Parents scared by the changes they see in their child, who have consulted a GP but been told not to worry, and for whom the situation has worsened, find that everyone in the home is in a state of distress and that their child is virtually starving. By this time, relationships in the family, including the parent's relationship, have often suffered. In general, parents will have tried everything that they can think of to encourage their child to eat – from begging, to bribing, to forcing – all the while arguing about the best thing to do. At the same time, their child will have done everything to keep from eating – from lying, to vomiting, to running away. Such parents often need to express emotions like guilt, anger and grief. They may need to confront these emotions before they can be receptive to information about their child's illness, their options, priorities, or their need for more education and support. They may even need to come into the Resource Centre for crisis counselling before they can decide what to do and how to do it.

People with eating disorders – A case study

Nearly a third of our calls are from people who have eating disorders, usually women in their twenties and older, who have had an eating disorder for several years. It may be the first time that the person has looked for help, or they may have had lots of counselling and are looking for something different, perhaps a support group. Very often they have sought help from various sources over the years but have been unhappy with the responses or services offered. The Resource Centre receives a significant number of calls from women who have seen a therapist some years earlier but had such a bad experience, they were hesitant to seek help again. The library is also a popular resource because helpful and up-to-date books on eating disorders are hard to find.

This case study is about a woman in her late twenties whose anorexia nervosa began in her teens and who subsequently developed bulimia nervosa without telling anyone. She had lived with the condition for years without seeking help because of a bad experience with therapy. She was suffering from depression and poor physical health, and was unable to carry on the profession she was trained for. She felt guilty about the way her life was affecting her parents, and felt like a failure. She moved around a lot, and had no stable friendships. While living in northern Queensland she went to a doctor for help and was referred to a psychiatrist who told her that no-one could help her with her problem. She felt that the doctors she had seen thought very poorly of her and she was embarrassed for having asked for help.

On her return to Brisbane, she read about the EDA Resource Centre in a magazine and decided to visit. She responded to a warm and accepting environment and delighted in finding a number of books written by people who understood what she was going through. She wanted to talk to other women who had experienced an eating disorder, and joined one of the Focussed Discussion and Support Groups. During this process, she decided to seek assistance from a health professional, specifically a psychiatrist who offered a Medicare rebate. Fortunately, the Resource Centre was able to refer her to a young female psychiatrist, recommended by another health professional, who was new to private practice and who didn't have a long waiting list at the time.

She was able to simultaneously see the psychiatrist and participate in the support group. This helped her to benefit from, and stay motivated with, both choices. She made some lasting and healthy friendships in the group, and remained in touch for some time by contributing to the Newsletter with book reviews and poems. Her mother also participated by attending the Family Information Workshops. The woman's relationship with her family has significantly improved. She has left an unhealthy partnership and has now found a good man. She is studying to become an artist and has her family's full support. Two years on from her first contact with the Resource Centre, she continues seeing the psychiatrist and her eating disorder has all but disappeared. She is doing well at college, and is in a stable relationship.

It had taken several years for this woman to find the help she needed. The Resource Centre was able to offer her appropriate advice and support when she needed it. Unfortunately, it is not always possible to get people into specialist services when they need them, as there are limited resources and there may be long waiting times, usually months. The Centre can provide stopgap support while the person is waiting for an appointment. On occasions, people become disillusioned with this process and by the time their appointment date arrives, have changed their minds about going ahead with treatment. Thus, we are often unable to use the window of opportunity people present us with. This is tragic for them and frustrating for us.

Health professionals – A case study

About 12% of calls are from health professionals who are seeking information to help a specific client. For instance, a counsellor in a small town in Queensland who is offering support to a woman with long-term anorexia nervosa, called for treatment information. We spent time talking about the various issues, sent photocopies of relevant information from the professional section of our library, and gave contact details for some professionals in Brisbane who might offer additional support. The counsellor's client had been in and out of the regional hospital several times and her condition was deteriorating. She had been sent to Brisbane to a private hospital with an eating disorder program, but felt too guilty about the expense, so returned home. Her marriage was in jeopardy, and she felt that her children were suffering because she was unable to feed them properly, or to physically cope with their care. The support and information offered by the EDA Resource Centre enabled the counsellor to feel more confident, but the services available to the woman with anorexia were inadequate.

The Resource Centre receives a significant number of calls from School Health Nurses who often feel overwhelmed by an expectation that they can address education issues related to eating disorders as well as intervene with those students who may have symptoms of an eating disorder. Such expectations are unrealistic, particularly as School Health Nurses have little in-service education related to eating disorders, and each nurse can be responsible for as many as 20 schools at a time. Depending on the need, we could provide information from our professional library or discuss the needs of a particular student. We might also provide additional information to be passed on to teachers and parents.

About 5% of our calls are from education professionals, usually about an individual student, but occasionally about health promotion/education programs. The calls typically relate to students with symptoms of anorexia, and the situation is usually that 'everyone' knows there is a problem but no one is willing or confident to take action. We are told that other students in the school are often distressed, knowing that the person has a serious problem but not knowing how to help.

Another example, is the case of a 14 year old who was attending dance classes at school. Her teachers had been concerned about this student for some time and had contacted her parents who seemed to deny that there was need for action. The school nurse contacted the EDA Resource Centre, and relevant information, which included an excerpt from a booklet written for coaches outlining 'duty of care' and legal responsibilities in regard to eating disorders, was mailed. The dance instructor and school principal were then able to make an informed decision regarding further contact with the student and parents. The family was advised by the school that professional assessment by someone knowledgeable about eating disorders was required. Ultimately, the student was found to have an advanced case of anorexia nervosa, and was provided with counselling, medical and dietetic care on an ongoing basis.

About 10% of our calls are from students – from secondary school to postgraduates at university. These students often spend hours in our library, as some of the materials are not readily available elsewhere. School students are sent a basic information package in the post, or are referred to the EDA Resource Centre website. Many of the students eventually disclose that they have an eating disorder. For this reason we ensure that students are always given information about self-help strategies and information for families.

Resource and funding issues

The service provided to people affected by eating disorders, is shaped very much by supporting services. We use considerable time and resources trying to find ways for clients to receive a minimum standard of care. Our experience is that compared with other mental health problems, clients with eating disorders are seriously underserved. It appears that mental health professionals are rarely able to offer effective, informed care, and usually don't want to. We have experience of requests from staff in this area of practise enquiring where to refer someone with an eating disorder because of an apparent unwillingness or inability to take them as clients.

In general, people with an eating disorder present to us with very complicated needs that challenge our limited resources. Although the role of the Resource Centre should primarily be one that facilitates social and peer support systems as well as providing self-help strategies, of necessity, at least half our efforts go towards finding ways to help people access adequate care. It is not unusual for us to hear of disturbing experiences that reflect perceived inadequacies in the health care system for this group of clients. Examples include accounts of being turned away from care, of feeling maligned by health professionals, or of receiving inappropriate advice. Even when clients can access informed care, the multi-level, multi-disciplinary approach recommended for effective treatment of eating disorders does not seem to be available, even in Brisbane. Consequently, the Centre is left to deal with the disappointment and frustration expressed by people who are now desperate for informed and empathic care. Of course, this frustration also extends to health professionals who are aware of the needs of their clients, but who do not have the resources or knowledge to enable them to offer an effective service.

Consequently, as the only service in Queensland specifically funded to provide information, referral and support to people affected by eating disorders, we often feel overwhelmed. Our experience tells us that there is a great deal of misinformation in the community, including the professional community, about eating disorders and related nutrition and treatment issues. From our perspective, there needs to be a more planned, and adequately resourced approach to community education. Providing self-help information and peer support is an important strategy to complement needed counselling/treatment and education/awareness programs, but it is currently the only dedicated service available to most people affected by eating disorders.

Resource

Powell, J. & Fleming, C. (1999). *Review of treatment services for people affected by eating disorders.* A Report funded under the Eating Disorders Grants Program, Office of Women's Policy, Queensland Government.

Consumer Perspectives

Sarah's Story

17 years old, finished Grade 12, and still recovered.

At the end of year nine I developed glandular fever. As a result, I had to miss a lot of school. When I was finally able to return, I felt out of place. My friends weren't mean or anything, but things had happened while I was away that I hadn't been a part of, and so, they naturally talked about things that made no sense to me. As the days went by I drew more and more into myself. I felt unimportant and out of place. I was also falling behind in most of my classes. Because I had missed out on quite a few lessons, I was having difficulty keeping up. I started dropping grades in areas that I'd always gotten top marks in.

Deciding to lose weight was not a conscious decision. I wasn't going out a lot so I didn't eat much junk food and I also had a part time job that kept me busy. At the beginning of the school holidays, I dropped a couple of kilos. The feeling I got out of seeing those numbers drop is almost inexplicable. I felt better than I had for months and so, naturally, when the feeling wore off, losing more weight was the obvious solution.

When I got back to school, people noticed the drop in my weight and for the most part, they encouraged me. Comments like: "You look great", and "You are so strong", fuelled my desire to lose weight. In class, my mind was consumed by thoughts of food, eating and weight. How much I would eat, when I would eat it, how I would eat it, how I would burn it off and how much fat was in it, how many calories, how I could get out of eating it, and on and on. My grades didn't matter that much any more and when sometimes I started to worry about them I would force the thoughts out of my head and replace them with dieting worries. People eventually started to worry about the drop in my weight, but when confronted, I would vehemently deny that I was dieting. I truly believed that if I lost just a little bit more it would be okay, that I'd be liked, that my friends would listen to me, that my marks would go up. I just had to find that magic number and everything would be fine. And every time the numbers dropped, I would feel truly elated, at least for a little while, and then like always it would wear off again. And so, I would just have to lose a little more.

Most of the time I could see what I looked like, see the bones, count the ribs, but it didn't matter. I thought I was fat because I still felt fat. And no matter how much weight I lost, I still felt fat. Technically, fat is not a feeling, but when you are a victim of this disease, saying you feel fat is the only way of describing what you feel. Everything else is blocked out. I was encompassed by this disorder and I didn't know any other way to think.

Going into hospital was for me, a voluntary thing, although I later pleaded to go home repeatedly. I wanted to get out of the house and be left alone, and I figured I could carry on the way I did at home while I was in hospital — with, of course, one added bonus, no parents. I was wrong. I eventually figured out that I would have to gain weight to be able to go home and get on with my life. It wasn't easy. I wish it was. I was in hospital for around two and a half months and during that time, I was nasogastrically fed. I went through ups and downs, threw things, shouted and cried, but eventually I reached my goal weight and was able to go home.

I'd like to say that when I returned home and went back to school that everything was okay. I'd like to say that, but I can't because it would be a lie. Things were hard, perhaps even harder, but I had the support of my family, friends, doctor and teachers.

It's two years later, and I still have my ups and downs. There is no simple way out of the disorder - but there is a way. When I look into the future and think of all the things that I want to do, I know that there is no place for anorexia anymore.

Reprinted with permission from:
Through the Looking Glass.
The Newsletter for the Eating Disorders Association (Qld)
Jan 1997, Vol 2, Issue 1, p. 3.

Living with Bulimia

Elizabeth's Story

Elizabeth has suffered with bulimia for the past 20 years. When she first started to binge and purge, there was no understanding of the disorder in the medical community. In 1979 the label of bulimia was given to the disorder but that didn't change her personal situation. Bulimia was then, and still is in a lot of cases, classed as a pathological condition requiring medical treatment.

Elizabeth described the trauma of not being able to tell anyone of her eating disorder and the double life she was required to live as a result. She discovered in silence, that whilst bulimia promised to be what she was looking for, a comforter and a friend, it turned out to be a great fraud. On the other hand, her eating disorder has been her greatest teacher. Her bulimia was simply a way of using her body to express her emotions. She developed a relationship with food: By eating she obtained comfort, and by vomiting she obtained release from anxieties, cleansing, purification and self acceptance.

For Elizabeth the issues were:

- self esteem - a sense of inadequacy and fear of rejection
- power and control - her bulimia was something that she thought she could control
- contradictions - Elizabeth found herself caught between the polarities of the condition - her nurturer became her enemy; the thing to live for could also be her death; no matter how 'full' she was, she still felt 'empty'.

It has taken a long time, but Elizabeth has now come to the realisation that she needs to trust and believe in herself. She commented on the need for more appropriate forms of treatment, in particular, she stressed the need to:

- treat the person as an individual - it is a unique journey for them.
- 'walk with' the sufferer - they hold their own answers. Treatment usually means "doing" to another. This is invasive and disrespectful.
- provide a healing relationship.
- model boundary setting - to set boundaries of more desirable eating patterns and behaviours *with* them and, in so doing, teach them these behaviours.

Elizabeth concluded by supporting frequently heard comments that existing programs are failing sufferers.

Reprinted from:
Gaskill, D & Sanders F. *Qld Health Eating Issues Forum: Proceedings and Recommendations*
Brisbane, 1995, p. 35.

Being in an at-risk industry – dance:

Katrina's story

Katrina was formerly a member of the Queensland Ballet Company. Whilst she has not suffered personally from an eating disorder, she was able to describe the pressures placed on young ballet dancers in this at-risk industry. She described the stereotypical dancer as thin, petite and striving for perfection physically as well as technically. The 'product' of the dancer is their body. She believes there is greater emphasis on being thin today than when she was in training because of messages in the media. Katrina also believes that she is very fortunate to have had a mother who insisted that she eat well, that education on the benefits of good nutrition begin at home. She has observed 'ballet mums' placing undue pressure on their budding ballerina children, depriving them of sweets and commenting on their weight. Whilst in fulltime dance, Katrina found the conversation between dancers, in the dressing room and so on, to concentrate on food. Obsessiveness about weight and shape is made worse by the fact that 'dancers spend 90% of their working day in front of a mirror.' Many take up smoking for stress relief and as an appetite suppressant. There are also those who use amphetamines on weekends to keep weight off for their Monday morning weigh-in and as a recreational drug.

The pressures of classical ballet dancing are enormous. Competition is fierce and often dancers are told to be thin if they aspire to a particular role. Katrina said basically, 'dancers will do anything to get THERE'. She pointed out, however, that competitiveness is less in smaller companies. Katrina also emphasised that dancers are often so absorbed in their art form that they have very little outside life. When they move out of home as adolescents, to take up full-time dance, they don't know how to shop, cook or eat properly. Yet dancers are athletes and need the sustenance of an athlete.

Dancers experience times when increased pressure is placed on them to watch their weight:

- pas de deux dancing, when the importance of being light and thin is made obvious because of the need to be lifted and held. It also constitutes early contact with the opposite sex.
- when a dancer sustains injury, and has time-off to recuperate, she is under pressure to ensure that she doesn't gain weight. This means that she often doesn't eat properly, which then hinders the recovery process.
- during holidays, when their more sedentary lifestyle makes them prone to put on weight.
- when touring on assignment away from home, where there is often inadequate access to nutritious food ie they are away from their own kitchens, and when they finish late at night, there are no shops open, apart from fast food outlets. This also applies more generally because of the long hours that they work. Frozen yogurt and diet coke was cited as the staple diet.

Katrina pointed out that other forms of dance, such as modern dance and eastern belly dancing, are more accepting of different body shapes and sizes. In concluding her talk, Katrina paid tribute to her parents for their support and attention which, she believes, made it possible for her to 'survive' full-time classical ballet.

Reprinted from:
Gaskill, D & Sanders F. *Qld Health Eating Issues Forum: Proceedings and Recommendations*
Brisbane, 1995, p. 37.

A Carer's Perspective:

Rowena

My daughter has had an eating disorder for the past six years, since the age of 14. On the advice of the local GP who couldn't get us out of the surgery quick enough, we went to a public hospital where she was admitted. Her first length of stay was seven weeks. It has been all downhill from there!

She had approximately three out of five years in various hospitals, the past 18 months, she hasn't been to any hospitals. We made a deal that as long as she didn't collapse in the street, we would not force her into this imprisonment. She has been constantly regulated, sectioned or imprisoned - which ever way you describe it. She has been constantly under the care of the mental health system, who thought they could do it better than we could - they failed. They failed and they lied. They didn't have the knowledge, they didn't have the right attitudes or skills, they certainly didn't have the compassion needed, and they made it a million times more difficult to keep asking for help. Between the appalling treatment and the blaming, they nearly killed all of us. We consider ourselves to be survivors of the system, and the treatment, rather than survivors of the illness.

The treatment is appalling. Young teenage girls in adult psychiatric wards, having to put nasogastric tubes into their own stomach, being denied basic human rights, not allowed visitors, not allowed flowers or cards, not allowed to get off the bed, not allowed to watch TV, not allowed to be with other patients, not allowed to shower in private (in case you hide some food), not even allowed the basic human dignity to go to the loo in private. Why is a few minutes of nasogastric feed worth more than a few minutes of dignity of a person who feels she does not deserve to be fed does not deserve to take up space in this world? This is treatment. If it was happening in Bosnia, we would be writing to complain. It is happening here and now, today, in some public hospitals somewhere. It makes it far too hard to ask for help if this is the deal you get when you do get the courage to ask.

It is an illness that society isn't comfortable with, it offends them to see these poor starving people in the midst of plenty. Let's get them off the streets, then we don't have to look at them. What are their parents thinking of - letting them go around like that? I'll tell you what they are thinking of, most of them are thinking 'Please God don't let her die before we find someone who cares'. The families of course are always dysfunctional families. We get used to health professionals either suggesting or assuming that. Of course we are dysfunctional families, our daughters are dying, we weren't necessarily dysfunctional before though, we thought we were a happy family, silly us - we need some help with that one.

And who helps us? There should be an eating disorder association in most of the city's you come from. They should know who has been stuck in the hospital for the last two months without a visitor, they should be in contact with the mothers and fathers of the sufferers just to give them a cuddle and say we do care and we are trying to make a difference. Just to give some hope. The future is important, but not at the expense of the present.

In some hospitals, things are slowly changing. In some hospitals things will never change. It has been a tentative foot in the door approach. It's time to break into the house, pee on the carpet, strangle the budgie and make a difference. Let's look for options and remember that:

Any treatment without care and compassion is not treating anything. I hope we find the passion to change it.

> Reprinted from:
> Gaskill & Sanders, *Challenge the Body Culture Conference Proceedings*
> Brisbane, 1998. pp. 75-76.

Closets are for Clothes

Suzy Trumball

I have a T-shirt that bears the message *Closets are for Clothes*. Being a lesbian, I know something about closets, since I have two closets to cower in, or come out of, that of 'nonstandard' sexual orientation and that of eating disorders.

I've done a lot of thinking about the gay closet. I know about the fear of others' loathing (a loathing based on bigotry fuelled by ignorance) that keeps gays and lesbians in the closet - and the cost to one's self-esteem and integrity that staying in the closet exacts. I also know why it's important to come out of the gay closet. As High Court Judge Michael Kirby, a gay man, has said, *It's always seemed to me...really ironic that some of the chief haters of gay people masquerade as followers of Jesus. But nothing will be changed in that respect unless people break the silence, and breaking the silence will end the game of shame.* Shame springs from one's sense of flouting the 'norm'. Gays internalize as shame the hatred or contempt that others show them just because their sexual orientation is different from that of the majority.

What about eating disorders? Why do people with eating disorders behave in such a secretive, furtive manner? Where does their shame come from? I think it comes at least partly from denial. At some level, one knows one is behaving abnormally (flouting the norm), but one doesn't want to admit that, because the disorder (not acknowledged to oneself as such, of course) is one's 'coping mechanism'. Besides, one doesn't want to be fat, whatever that is.

For gays, coming out of the closet means repudiating shame and reclaiming integrity. I think it means, first and foremost, coming out to oneself: naming names, acknowledging the disorder as a disorder, as a dysfunctional pattern rather than an effective coping mechanism. Admitting this is every bit as scary as coming out to others is for a gay or lesbian person, because it means stepping out of one's safe, if soul-destroying, hiding place. Next, coming out of the eating disorder closet means, perhaps, coming out to those who are intimately involved in one's life and are suffering as they stand by watching helplessly as one destroys oneself, whether parents, a sibling, a best friend, or a partner. Third, it means reaching out for help.

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An initiative of the Eating Disorders Association Inc (Qld)

Exploring Eating Disorders: The use of Drama in Secondary Schools

Marian.

I'd first like to introduce myself as a feminist, an arts worker, a student politician working for the QUT Student Guild Women's Department and also as a person recovering from bulimia. Mostly today, I will be talking about Closet I.D. and my involvement with Cliche Theatre Company. Closet I.D. is a multi arts form production that is about body image, eating disorders, and the role of the media and the fashion industry and it's influence on our construction of our identity, self esteem and body image. It also focuses on plastic surgery. The devising of Closet I.D. began in May, 1995, when six individual women, all studying a Bachelor of Arts (Drama) at QUT in their second year, formed a unique collaboration to complete an assessment item. We all wanted to devise an original work and when we first began talking, we each had a common interest and concern with body image and identity. Our devising process began, and we performed the original Closet I.D. in December, 1995. The original production was site specific and interactive and performed to a maximum audience of 30 people in a small space. Feedback that we received from high school teachers and a few medical professionals was that the content was extremely relevant to young people and high school students, and they suggested that we should consider performing the show in high schools – so we did. With this support, four of us remodelled and re-devised the show and auditioned it for the Queensland Arts Council Schools Touring Program. That was in June, 1996. We were then successful in receiving a place in the Touring Program and with further development of the show we devised another 30 minutes of content. We did this with the Gender Equity Unit of Qld Education and the Arts Council. We also work with a director and dramatist. We also had the thrill of working with a real set for the first time!

At this stage, I'll briefly talk about the process used to devise the new material. The four of us work in a collaborative process, with most of the time achieving consensus. We also have specific skill areas that we each focus on. We all work within a feminist framework, each of us with separate politics and beliefs. In July, 1997 we began a six week season in south east Queensland high schools. We have performed as far south west as Stanthorpe and Warwick and as far north as the tip of the Brisbane metropolitan region, Pine Rivers Shire. We've travelled to two different schools each day and performed an average of three shows a day or 15 shows a week. The response we've had to date has been extremely encouraging and extremely positive. At some schools, we are received as heroes, especially at schools where the concept of body property and body ownership are not something that is widely accepted or even heard of. We find it ironic that when we perform Closet I.D., we endure constant harassment and abuse about our own bodies and that a lot of adolescents still have trouble with the concept of women touching their own body or touching other women's bodies. At the end of each performance we have time for discussion with students. It is during this time that we have an opportunity to talk about the health risks of eating disorders and also provide students with phone numbers and counselling information and support. This is, of course, provided that students themselves respond to our offer to receive the information. At one particular school, we were told by one of the teachers that: "We have an anorexic at the school". I often think of the show discussion time as an opportunity to introduce new language to both teachers and students, to use language that does not recognise someone by their disability or illness, but as a complete and whole person first. I was also in a position where I wanted to suggest to the teacher that there were probably several students at the school who had eating disorders or disordered eating patterns and not just the one student or "an anorexic" that he knew of.

On our first day of touring, being naive about school environments, I was shocked to discover how some students are towards the issues we'd been presenting. In the show, I portray a character with bulimia. As part of this, I perform a binge scene. There were several students, mostly males, making 'throwing up' noises and mocking my character's illness. At first I took great offence at this, being a recovering bulimic myself. I quickly learnt how to separate my own experiences and most of those of my characters to maintain a stable sense of self and perform the show every day. In this respect, this show is not a form of therapy that I have created for myself. However, I do believe it has made me a stronger person, it has made me confront myself, and be honest with myself which I believe is one of the first, essential steps to starting a recovery process from an eating disorder.

I first practiced and learnt how to become a successful bulimic during years 11 and 12 at an all girls private high school. I shopped around the eating disorders market. Although I tried out anorexia, I was never successful. I believe that high school can be the perfect breeding ground for eating disorders. I found that being in an all female environment, where bodies were openly talked about and eating was openly talked about, that I learnt all the secrets of the trade and it was very easy to do.

I guess it's also important to recognise at this stage the limitations of our performance language, ie that the material has been devised and performed by four, white, middle class women and that what our experience and concerns are, do not represent the concerns of all students.

We have, on occasions, been criticised about our collective body sizes, the four of us do not have particularly high amounts of body fat, so some people, both high school students and adults, suggest: Well, what would we know about body eating disorders anyway. I'm always quick to point out that you can't judge an individual's perception of themselves and their body image, based on their size.

It's been an incredible journey for the four of us. In some schools we are the first opportunity students are provided with to start talking about their own experiences of disordered eating patterns or those of best friends, for their poor self image and their poor self esteem. We've had many of the students' stories shared with us about these issues. While it is encouraging to begin a process of opening doors and speaking channels, I found it bitterly frustrating, that while we could enter a school environment with Education Department approval, and speak openly about eating disorders and the fact that people really do have them, we were not allowed to talk about sexual abuse. I find it almost inconceivable to talk about one, and not mention the other. At least we were able to introduce the notion of control being intrinsically linked to eating disorders and disordered eating patterns.

Last week, we were informed by the Queensland Arts Council that we would not be part of their 1998 touring program, because, as a four person company, we were too expensive. Now that we have initiated change by having six weeks access to high schools in 1997, we are determined to repeat this in 1998 by seeking funding from other sources. This is provided that our government still continues to recognise the importance of this issue and the capacity for a 50 minute theatrical performance to create real change and provide the key to future strategies of dealing with body image and eating disorders in schools.

(Some of) the feedback that we have received from our tour is: Do you do this show for primary school students? There is an obvious need for these issues to be addressed in curricula, not just in high schools, but also in primary schools. It is, of course, no surprise, that what has now been released is a new Barbie magazine for 6 to 12 year olds which is absolutely appalling. The other problem that exists, is that women's magazines form such a large part of young women's culture, and, as Professor Glen Waller has mentioned, it is impossible to have positive legislation on advertisements and the advertising and fashion industry. So what we really need to do is to find money to create a magazine that is not about fashion and how thin we can look, but one that creates positive representations of women and creates a positive culture for young women, since this seems to be the medium that they respond to. I think it's very encouraging that conferences like this are happening. We have performed the show at a number of similar gatherings, and it's better that we do this more often each year. So I'd like to congratulate the organisers of this conference and everyone who is here to attend and to start working on this issue.

Reprinted from:
Gaskill & Sanders, *Challenge the Body Culture Conference Proceedings*
Brisbane, 1998, pp. 77-79.

From a mother...

...To my daughter

You are so alone, wandering within your mind
So sad, so guilty, so mean on yourself.
I reach out to gather you away from that deep bad world.

Sometimes you can reach me and step overthat wall and feel my love and warmth.
I can envelope you in my heart.
Sometimes our fingers can only just touchand I can't get a good grip to help pull you out.
Sometimes I can only just see you and my love can't get in.
I want to bang at that wall.
I want to kick and yell and scream.
I'm helpless.
I can't protect. I can't do anything.
I go into a frenzy,
there must be something
I haven't thought of.
Something that can save my little girl.
How can I make her see how lovely she is?
How beautiful her inner self really is?
How many people love her?
Because she is special to us.
WE LOVE YOU!

Reprinted with permission from:
Through the Looking Glass.
The Newsletter for the Eating Disorders Association (Qld)
June 1997, Vol 2, Issue 6: 3.

...and a brother

Thank-you Society

Dearest Society, what have you done?
My sister has bulimia.
My mother blames herself for the terrible
Upbringing she must have given this girl.
And my sister sinks in her self pity.

But I blame you, Society, and I thank you from the bottom of my heart.

Why don't you take your beautiful models and your muscle men
And leave me and my sister alone.
I don't want to know how you think my sister should look.
Because I think she is beautiful

Although the back of her teeth are rotting away
From the acid attacks they receive over eight times a day.
When my sister vomits up whatever food she has just eaten
I still think she is beautiful.

But I don't think that your models are beautiful.
I hate them all.

Dear Society,
Please flush all your models and your muscle men
Down the toilet with my sister's vomit where they belong.

And, dear Society, please leave my sister alone.

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ABNSG, 1997

Epilogue

There is a stigma associated with eating disorders. As with suicide, when sufferers die from an eating disorder, many families prefer to tell friends and the community they live in that their loved one died from another cause.

In the relatively short time that this book has been with the publisher, at least three Brisbane women in their early twenties and thirties lost their battle with anorexia nervosa. Our thoughts are with their family and friends and the hundreds of other teenagers and young adults who are battling with an eating disorder.

The Editors

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